Uniform Medical Plan

Your health. Your plan. Your choice.

Billing & Administrative Manual

for Professional Providers

Visit the UMP Web site at **www.ump.hca.wa.gov** to download the latest versions of this billing manual, and all other UMP publications mentioned in this document.

Washington State Health Care Authority

Public Employees Benefits Board

HCA 54-689 (2/04)

Updated 2/04

Uniform Medical Plan
Your health. Your plan. Your choice.
Washington State Health Care Authority
PO Box 91118■Seattle, WA 98111-9218
206-521-2000■Fax 206-521-2001■TTY/TDD 360-923-2701
www.ump.hca.wa.gov

Dear Provider:

Thank you for participating in Uniform Medical Plan (UMP) provider network(s). Enclosed are billing instructions that we hope you will find helpful. The UMP is a self-insured, preferred provider medical plan designed by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority (HCA). Our motto—*"Your health.Your plan.Your choice."*—reflects UMP's philosophy, emphasizing freedom of choice paired with enrollee responsibility for care management.

The UMP offers one of the largest published provider networks in the state of Washington, as well as a nationwide retail pharmacy network with a mail-order option.

Since the UMP's benefit structure requires cost-sharing on the enrollee's part, this works to promote the responsible use of health care resources. The UMP encourages providers and enrollees to work together to achieve optimal health outcomes at an acceptable cost. In today's environment, many health care consumers covered by insurance are not aware of the true cost of health care services; the UMP's cost-sharing structure tends to enhance awareness.

The UMP also administers UMP Neighborhood, a new pilot product that provides coverage to a limited number of enrollees in King, Snohomish, and Pierce counties. Enrollees in UMP Neighborhood receive the same benefits as those enrolled in the UMP's traditional preferred provider organization (PPO), but through a more limited choice of network providers.

Please take the time to review this *UMP Billing & Administrative Manual*, as well as our current *Certificates of Coverage* (COCs) and *Preferred Drug List* for the UMP and UMP Neighborhood. We have added information pertaining to UMP Neighborhood to the UMP Billing Manual in Appendices A-5 to A-8.

You may also access these documents, fee schedules, and other information pertaining to UMP and UMP Neighborhood by visiting our Web site at **www.ump.hca.wa.gov**. In addition, the Web site provides access to online network provider directories for UMP and UMP Neighborhood, which are updated on a monthly basis.

We are here to help you and your staff. If you have any questions regarding UMP policies and procedures, fee schedule information, or if you need additional training, please do not hesitate to call us toll-free at 1-800-292-8092, or locally at 206-521-2023. To confirm patient eligibility, call toll-free 1-800-335-1062; you will need to have the subscriber identification number to access eligibility information. When prompted by the automated system, you should choose the number which selects "PEBB subscriber information."

We are pleased to have you as a network provider, and look forward to working with you to provide quality care and customer service to all of our enrollees.

Sincerely,

Janet Peterson
Executive Director

Andrew J. Brunskill, M.D.
Medical Director

Mary Kay O'Neill, M.D.
Associate Medical Director

Table of Contents

Section 7: Payment Rules (cont.)

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Section 8: Provider Inquiries, Complaints, Reconsideration Procedures, and Dispute Resolutions

Appendices

To obtain this booklet in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Section 1

Quick Reference Notes

1.1

How to Reach Us

Uniform Medical Plan Web site:
www.ump.hca.wa.gov

1.1.1 Addresses and Phone Numbers

Uniform Medical Plan Customer and Provider Services

- Benefits information
- Claims status and information.
- Enrollee eligibility information*
- General billing questions
- Interactive Voice Response (IVR) system
- Medical review
- Prenotification/preauthorization
- Verify provider's network status

***Automated Enrollee Eligibility Information:**
Toll-free 1-800-335-1062

(Have subscriber I.D. number available, and select #2 for "PEBB subscriber information.")

Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

Provider Services:
Toll-free 1-800-464-0967

Local 425-670-3046

Fax 425-670-3199

Active Enrollees:
Toll-free 1-800-762-6004

Retired Enrollees:
Toll-free 1-800-352-3968

Case Management Services:
Toll-free 1-888-759-4855

Electronic Claims Submission:
The following clearinghouses frequently submit claims electronically to the UMP.

Electronic Network Systems (www.enshealth.com)

Toll-free: 1-800-341-6141

WebMD/Envoy (www.WebMD.com)

Toll-free: 1-800-215-4730

ProxyMed (www.proxymed.com)

Toll-free: 1-800-586-6870

Provider Credentialing and Contracting Issues

- Billing manuals and payment policies
- Change of provider status
- Fee schedules
- Network provider applications and contract information
- New provider enrollment
- Policies and procedures
- *Provider Bulletin* feedback

Health Care Authority
Uniform Medical Plan
P.O. Box 91118
Seattle, WA 98111-9218

Toll-free 1-800-292-8092

Local 206-521-2023

Fax 206-521-2001

Licensed Acupuncturists, Licensed Massage Practitioners, and Naturopathic Physicians Network

- Network provider applications and contract information
- Billing procedures
- Fee schedule and payment policy information

Alternáre Health Services, Inc.

Toll-free 1-800-500-0997

Local 206-405-2923

Prescription Drugs (retail and mail-order)

- Benefits information
- Claims information
- Cost share information
- Eligibility verification
- Preferred drug list information
- Prior authorization requests
- Network pharmacy information (location and network verification)

Express Scripts, Inc.

To fax prescriptions (providers):

Toll-free: 1-800-396-2171

Fax on provider's letterhead to expedite processing (see Section 7.17).

To call in prescriptions (providers):

Toll-free:..... 1-800-763-5502

Drug Coverage Review and Prior Authorization:

Toll-free:..... 1-800-417-8164

Fax: 1-877-697-7192

Appeals and Correspondence:

Toll-free:..... 1-800-417-8164

Fax: 1-877-852-4070

Express Scripts, Inc.
Attn: Pharmacy Appeals: WA5
Mail Route BL0390
6625 West 78th Street
Bloomington, MN 55439

Tobacco Cessation Services

Free & Clear

Toll-free:..... 1-800-292-2336

1.1.2 Web Site Information

Uniform Medical Plan
www.ump.hca.wa.gov

- Billing & Administrative manuals
- *Certificate of Coverage* (benefits book)
- *Network Provider Directory*
- *Preferred Drug List*
- *Professional Provider Fee Schedule*
- *Anesthesia Fee Schedule*
- *Chiropractor Fee Schedule*
- *Prosthetic and Orthotic Fee Schedule, Including Ostomy and Urological Supplies*
- Other important UMP information

U.S. Preventive Services Task Force Guidelines
www.ahcpr.gov/clinic/uspstf/uspstables.htm

- Preventive care guidelines

Express Scripts, Inc.
www.express-scripts.com

- General prescription drug information

Note: See the UMP Web site (**www.ump.hca.wa.gov**) for UMP-specific information for prescription drugs.

Free & Clear
www.freeandclear.org/brochure

- Tobacco cessation program information

Alternáre Health Services, Inc.
www.alternare.com

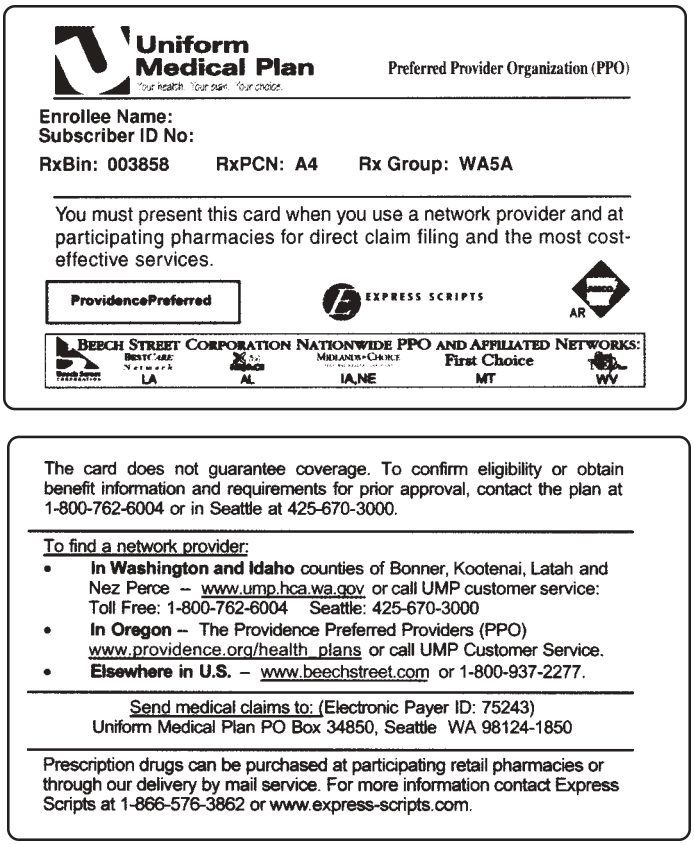
- Licensed Acupuncturists, Licensed Massage Practitioners, and Naturopathic Physicians—network provider resources information

1.2

Sample Uniform Medical Plan Identification Card

This is the identification card that confirms UMP PPO enrollment. Each UMP PPO enrollee is issued an identification card with a unique 9-digit number prefixed by a "W." Please note that the UMP no longer uses social security numbers for eligibility and claim records. Please use the "W" number on all claims and inquiries.

A sample of the UMP Neighborhood identification card is included in Appendix A-5, Section 1.2.



1.3

Claims Submission Information

Paper claims (CMS-1500) should be mailed within 60 days of service (but not beyond 365 days) to the UMP claims office at the following address:

Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

Claims with missing, inaccurate, or invalid information will be denied or sent back for clarification and resubmission.

Electronic claims submission provides efficiency to your business.

If you are already connected to one of the following clearinghouses that frequently transmits claims electronically, continue to submit your UMP claims to payer I.D. number 75243.

Electronic Network Systems (www.enshealth.com)
Toll-free:..... 1-800-341-6141

WebMD/Envoy (www.WebMD.com)
Toll-free:..... 1-800-215-4730

ProxyMed (www.proxymed.com)
Toll-free:..... 1-800-586-6870

If you are currently submitting paper claims, we encourage you to contact a clearinghouse for information on submitting claims electronically.

1.4

Provider Network Participation

UMP PPO benefits are structured to encourage enrollees to use the services of network providers. As a financial incentive and to promote quality of care, the plan provides for considerable cost sharing for enrollees who do not use network providers.

As a preferred UMP provider, you are expected to refer patients to other preferred providers. Contact the UMP at 1-800-464-0967 or 425-670-3046 when you need to confirm a provider's participation in the network. If the patient is a UMP Neighborhood enrollee, see Appendix A-5 for referral information and pass requirements.

The UMP recognizes that most physicians have established referral patterns and we do not wish to disrupt them. If the providers you routinely refer to are not UMP PPO network providers, but are interested in joining the UMP PPO network, please refer them to the Provider Services Division by calling toll-free 1-800-292-8092, or locally 206-521-2023. Non-network providers will also be solicited at your request. Please note, however, that all providers must meet UMP credentialing criteria prior to receiving network provider status.

UMP PPO is not a closed network. However, due to administrative resource constraints, we have established priorities for adding new providers. UMP is focusing on the credentialing of applicants in specialties and geographic areas where additions to the UMP PPO network are critical for enrollee access to care. When a request or application is received from a provider for a non-priority area, the provider is notified that we will not be processing the application at this time. Applicant information is retained for future consideration. UMP routinely analyzes statewide network adequacy in relation to the location and needs of our enrollees.

Section 2

Program Outline

Questions regarding fee schedule development and administration? Call 206-521-2023 or 1-800-292-8092.

2.1

Overview of the Uniform Medical Plan Preferred Provider Organization (UMP PPO)

The Uniform Medical Plan Preferred Provider Organization (UMP PPO) is a self-insured, preferred provider plan for public employees and retirees. It is sponsored by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority.

UMP PPO coverage includes medical, surgical, and obstetric services; chemical dependency and mental health treatment; organ transplants; and prescription drugs. All enrollees have benefits for routine preventive care, vision and hearing examinations, tobacco cessation services, and diabetic education.

See the UMP *Certificate of Coverage* (available on the UMP Web site at **www.ump.hca.wa.gov** or by calling 1-800-762-6004) for deductible, coinsurance, and copayment requirements, as well as for a complete description of plan benefits and scope of coverage.

2.2

The Uniform Medical Plan Fee Schedule Based on Resource Based Relative Value Scale (RBRVS) Methodology

2.2.1 RBRVS Overview

The Resource Based Relative Value Scale (RBRVS) methodology is used by the three primary purchasers of health care in Washington State:

- **The Health Care Authority (HCA)** – The state agency that administers the UMP for public employees and retirees.
- **The Department of Labor and Industries (L&I)** – The state agency that administers the state's workers' compensation program (State Fund Industrial Program only).
- **The Department of Social and Health Services (DSHS) Medical Assistance Administration (MAA)** – The state agency that administers the state's Medicaid program.

These three agencies form a group known as the Reimbursement Steering Committee (RSC) to develop, maintain, and update the fee schedules and payment policies. Under the RBRVS approach, the agencies have a common set of relative value units. While the basis of the fee schedules is the same for the state agencies, payment levels differ because agency-specific conversion factors are used. Advice is provided by the State Agency Technical Advisory Group (TAG), which represents most major provider specialties in the state. The technical elements as well as the process for developing and maintaining the fee schedule are discussed below.

2.2.2 RBRVS Technical Elements

The UMP statewide fee schedule is based on relative value units (RVUs) and a conversion factor. The RVUs are geographically adjusted for Washington State. The primary sources for the RVUs and geographic adjustment factors are the Medicare Physician Fee Schedule Data Base and *Federal Register* publications. The RVUs from these sources are established by the Centers for Medicare & Medicaid Services (CMS), based on the resources required to perform each service, such as the work, practice expense, and liability insurance.

Fee schedule allowances are generally updated on an annual basis as new RVUs become available. Fee schedule allowances are available on the UMP Web site at **www.ump.hca.wa.gov** or upon request by calling the numbers at the beginning of this section.

2.2.3 Procedure Codes and Modifiers

The state agencies identified in 2.2.1 have adopted common coding rules to use and follow the most recent updated version of Physician's Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) level II procedure codes and modifiers to the extent possible.

CPT procedure codes are revised and published each year by the American Medical Association (AMA). The annual updates are generally published in November, and become effective on January 1 of the following year. Additional updates to CPT category I, II, and III codes are also electronically released on the AMA Web site for use as of January 1 and July 1 in a given CPT cycle.

Please note: CPT category II codes (e.g., CPT codes 0001F—0011F) are valid for tracking purposes but they are not recognized for payment purposes.

HCPCS level II procedure codes are maintained by the Centers for Medicare & Medicaid Services and are also published annually. Periodically, additional new HCPCS codes are added by CMS during the year, which are released via their program transmittals and/or the Web site. HCPCS level II procedure codes are published by the U.S. Government Printing Office and by a number of commercial publishers.

Deleted CPT or HCPCS level II procedure codes will be accepted for only 90 days after new publications identify them as deleted and invalid.

Due to its licensing agreement with the American Medical Association, the UMP *Billing & Administrative Manual* contains abbreviated definitions of procedure codes. For billing purposes, please refer to the most current edition of the CPT and HCPCS books for complete descriptions of the procedure codes.

The use of modifiers is explained in more detail in Sections 7.1.5, 7.2.5, and 7.3.3 of this manual.

2.2.4 Included Services

Care provided by physicians and other practitioners related to the following services will be reimbursed under the UMP fee schedule based on the RBRVS methodology:

- Chemical dependency
- Diagnostic studies
- Family planning
- Hearing care
- Hospital outpatient and emergency care
- Laboratory services
- Medicine, including allergy, immunology, and dermatology
- Mental health care
- Obstetric and newborn care
- Office visits and institutional visits
- Physical, occupational, and speech therapy
- Preventive care
- Radiation and chemotherapy
- Spinal and extremity manipulations
- Surgery
- Vision care

Please refer to the UMP *Certificate of Coverage* for details regarding scope of coverage of these benefits.

2.2.5 Excluded Services

Certain groups of procedures, although covered by the UMP, are excluded from RBRVS pricing. Excluded services include:

- Ambulance and transportation services
- Dental services
- Durable medical equipment
- Inpatient, outpatient, and facility fees
- Medical supplies
- Pharmacy services
- Prosthetics/orthotics (see the UMP *Certificate of Coverage* for limited orthotic coverage)

2.2.6 Payment

The Health Care Authority uses the UMP fee schedule referenced throughout this document as a schedule of UMP maximum allowances for network and non-network professional providers in Washington State. **The allowable amount is the lesser of the**

provider's actual charge or the UMP fee schedule amount.

Please note: The UMP fee schedule referenced throughout this document is not used for payment of services provided by naturopathic physicians, massage therapists, and licensed acupuncturists. Covered services by these provider types are reimbursed according to the Alternáre Health Services Fee Schedule allowances, billing rules, and payment policies. Also, the UMP fee schedule generally applies only for services in Washington State or border counties of Oregon and Idaho.

Section 3

Billing Instructions

Questions regarding billing procedures? Call 206-521-2023 or 1-800-292-8092.

3.1

Instructions for Completing CMS–1500 Claim Forms

All professional claims must be submitted on CMS–1500 claim forms. The following instructions specify how to complete each required field on the CMS–1500 for claim payment. Field numbers and names shown in **bold type** signify very important information. If this information is missing or inaccurate, claims processing may be delayed or denied. A sample CMS–1500 form (Exhibit 3-1) follows these instructions.

No.	Field Name	Instructions
1	Coverage Type	Check the box labeled Group Health Plan. Check other types of coverage as applicable.
1a	**Insured's I.D. Number**	**Enter the insured's UMP identification number.**
2	**Patient's Name**	**Enter the patient's full name (last name, first name, middle initial).**
3	**Patient's Birth Date**	**Enter the patient's date of birth in MM/DD/YYYY format. For example, July 8, 1950, would be entered as 07/08/1950.**
	Sex	**Check the appropriate box: M=male, F=female**
4	**Insured's Name**	**Enter the name of the insured, except when the insured and the patient are the same (then the word "Same" may be entered).**
5	**Patient's Address**	**Enter the patient's permanent mailing address and telephone number. On the first line, enter the street address; the second line is for the city and state; the third line is for the ZIP Code and phone number.**
6	**Patient Relationship to Insured**	**Check the appropriate box: Self, Spouse, Child, or Other. If Other, describe the relationship.**
7	**Insured's Address**	**Enter the insured's address and telephone number, except when the address is the same as the patient's (then the word "Same" may be entered). Complete this field only when fields 4, 9, or 11 are completed.**
8	**Patient Status**	**Check all boxes that apply: Single, Married, or Other; and Employed, Full-Time Student, Part-Time Student.**
9	**Other Insured's Name**	**If the patient is covered by other insurance, enter the last name, first name, and middle initial of the other plan's policyholder if it is different from that shown in field 2. Otherwise, enter the word "Same."**
9a	**Other Insured's Policy or Group Number**	**If the patient is covered by other insurance, enter the policy or group number of the plan.**

No.	Field Name	Instructions
9b	**Other Insured's Date of Birth**	**If the patient is covered by other insurance, enter the policyholder's date of birth in MM/DD/YYYY format. For example, July 8, 1950, would be entered as 07/08/1950.**
	Sex	**Check the appropriate box: M=male, F=female**
9c	Employer's Name or School Name	If the patient is covered by other insurance, enter the name of the policyholder's employer or school, if applicable.
9d	**Insurance Plan Name or Program Name**	**If the patient is covered by other insurance, enter the other insured's plan name or the program name (i.e., the patient's health maintenance organization).**
10	**Accident Determination**	**If the patient's condition is accident-related, check the appropriate box: Employment, Auto Accident, or Other Accident.**
11	**Insured's Policy Group or FECA Number**	**Enter the policy number of the insured's Uniform Medical Plan: 029.**
11a	**Insured's Date of Birth**	**Enter the insured's date of birth and sex, if different from item 3.**
11b	**Employer's Name or School Name**	**Enter the employer name or school name for the insured.**
11c	**Insurance Plan or Program Name**	**Enter the plan name: Uniform Medical Plan.**
11d	**Other Health Benefit Plan**	**Check "Yes" or "No" to indicate whether there is another primary health benefit plan. For example, the patient may be covered under insurance held by a spouse, parent, or some other person. If there is information in fields 9 through 9d, "Yes" must be checked. If "No" is checked, then these items would be blank. *If "Yes" is checked and fields 9 through 9d are blank, claims processing will be delayed.***
12	**Patient's or Authorized Person's Signature**	**Have the patient or his/her authorized representative sign and date this block unless the signature is on file.**
13	Insured's or Authorized Person's Signature	Optional, can be left blank.
14	**Date of Current Illness, Injury, or Pregnancy**	**Enter date of onset of current illness, injury, or pregnancy.**
15	Date of Same or Similar Illness	Leave blank.
16	**Dates Patient Unable to Work in Current Occupation**	**Enter date if patient is unable to work. An entry in this field could indicate employment-related insurance coverage. If this item is applicable, field 10 (Accident Determination) may also require completion.**
17	**Name of Referring Physician or Other Source**	**If the services are the result of a referral, then enter the name of the referring physician.**
17a	I.D. Number of Referring Physician	Optional, may be left blank.

No.	Field Name	Instructions
18	Hospitalization Dates Related to Current Services	Optional, may be left blank.
19	Reserved for Local Use	Optional, may be left blank.
20	Outside Lab	Complete this item when billing for diagnostic tests subject to purchase limitations. Enter the purchase price under charges if the "Yes" block is checked. A "Yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "No" check indicates that no purchased tests are included on the claim. When "Yes" is annotated, field 32 must be completed.
21	**Diagnosis or Nature of Illness or Injury**	**Enter up to four ICD–9–CM diagnosis codes in priority order (primary, secondary condition). Report the highest level of specificity. Enter the appropriate diagnosis code for screening mammography.**
22	Medicaid Resubmission	Leave blank.
23	Prior Authorization Number	Optional, may be left blank.
24a	**Dates of Service**	**Enter the month, day, and year for each procedure, service, or supply. If "from" and "to" dates are shown here for a series of identical services, the number should appear in field 24g.**
24b	**Place of Service (POS)**	**Enter the code which describes the place of service:**

Please note:
This field is required or the claim will be denied. Place of service code "11" (office) may not be used for services furnished in hospital outpatient departments or hospital-based entities (i.e., any clinic that meets CMS's criteria for "provider-based" designation). Use place of service code "22" (outpatient hospital) or, if applicable, "23" (emergency room-hospital) in this circumstance.

03	**School**
04	**Homeless Shelter**
05	**Indian Health Service Free-Standing Facility**
06	**Indian Health Service Provider-Based Facility**
07	**Tribal 638 Free-Standing Facility**
08	**Tribal 638 Provider-Based Facility**
11	**Office**
12	**Home**
13	**Assisted Living Facility**
14	**Group Home**
15	**Mobile Unit**
20	**Urgent Care Facility**
21	**Inpatient Hospital**
22	**Outpatient Hospital**
23	**Emergency Room – Hospital**
24	**Ambulatory Surgical Center**
25	**Birthing Center**
26	**Military Treatment Facility**
31	**Skilled Nursing Facility**
32	**Nursing Facility**
33	**Custodial Care Facility**
34	**Hospice**
41	**Ambulance (Land)**
42	**Ambulance (Air or Water)**
49	**Independent Clinic**
50	**Federally Qualified Health Center**
51	**Inpatient Psychiatric Facility**
52	**Psychiatric Facility Partial Hospitalization**
53	**Community Mental Health Center**

No.	Field Name	Instructions
		54 Intermediate Care Facility/Mentally Retarded **55 Residential Substance Abuse Treatment Facility** **56 Psychiatric Residential Treatment Center** **57 Non-Residential Substance Abuse Treatment Facility** **60 Mass Immunization Center** **61 Comprehensive Inpatient Rehabilitation Facility** **62 Comprehensive Outpatient Rehabilitation Facility** **65 End Stage Renal Disease Treatment Facility** **71 State or Local Public Health Clinic** **72 Rural Health Clinic** **81 Independent Laboratory** **99 Other Unlisted Facility**
24c	Type of Service	Leave blank.
24d	**Procedures, Services, or Supplies**	**Enter the appropriate procedure code and modifier, if applicable. Only current CPT and HCPCS level II procedure codes (with appropriate modifiers, where required) will be accepted for payment. For each procedure, show the corresponding diagnostic code in field 24e.**
24e	**Diagnosis Code**	**Enter the diagnostic code reference as shown in field 21, to relate the date of service and the procedures performed to the appropriate diagnosis.**
24f	**Charges**	**Enter the billed amount.**
24g	**Days or Units**	**Show the days, units, or anesthesia minutes in this block. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.**
24h	EPSDT	Leave blank.
24i	EMG	Check this item to indicate that the service was rendered in a hospital emergency room. If this block is checked, then the place of service code in field 24b should match.
24j	COB	Leave blank.
24k	Reserved for Local Use	Optional, may be left blank.
25	**Federal Tax I.D. Number**	**Show the physician/supplier federal tax I.D. number (employer identification number) or social security number.**
26	Patient's Account Number	Enter the patient's account number assigned by the physician's/supplier's accounting system. This is an optional field to enhance patient identification by the physician or supplier.
27	Accept Assignment?	Leave blank.

No.	Field Name	Instructions
28	**Total Charge**	**Enter the total of the charges listed for all line items.**
29	**Amount Paid**	**Enter the amount received from a third party. If another insurer has processed a claim for these services, an Explanation of Benefits (EOB) must be attached to the claim.**
30	Balance Due	Enter the balance due (field 28 less field 29).
31	**Signature of Physician or Supplier**	**The provider must sign or signature stamp each claim for services rendered, and enter the date. Only signed claims will be accepted for payment.**
32	**Name and Address of Facility Where Services Were Rendered**	**Enter the name and address of the facility where the services were rendered.**
33	**Physician's/Supplier's Billing Name, Address, Etc.**	**Enter the billing provider's name, address, and phone number.**

Exhibit 3-1: CMS-1500 Claim Form

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) ✓

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ✓

3. PATIENT'S BIRTH DATE ✓ MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial) ✓

5. PATIENT'S ADDRESS (No., Street) ✓

6. PATIENT RELATIONSHIP TO INSURED ✓ Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street) ✓

CITY | STATE

8. PATIENT STATUS ✓ Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) ✓

10. IS PATIENT'S CONDITION RELATED TO: ✓

11. INSURED'S POLICY GROUP OR FECA NUMBER ✓

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

✓ SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: ✓ MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION ✓ MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE ✓

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) ✓

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 ✓		✓		✓		✓	✓	✓				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER ✓ SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO. ✓

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ ✓

29. AMOUNT PAID $ ✓

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) ✓ SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) ✓

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # ✓ PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

3.2

Claim Submission Procedures

Questions regarding claims submission? Call 425-670-3046 or 1-800-464-0967.

3.2.1 Claim Submission Process

Claims submitted on paper must be mailed to the UMP:

Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34850
Seattle, WA 98124-1850

Providers are required to use the CMS-1500 claim form. Incomplete claims will cause delay or denial of claims payment. Services submitted with invalid procedure, diagnoses, or place of service codes will be denied.

You are encouraged to submit claims electronically. See Section 1.3, Claims Submission Information, to find out more about this option.

3.2.2 Timely Submission of Claims

Claims for covered services provided to an enrollee should be submitted within 60 days of the date of service. The UMP will not process claims submitted more than 12 months after the date of service. Under exceptional circumstances such as when the UMP is secondary and the primary payer has not paid on a timely basis, this provision may be waived upon approval by the UMP.

To request a waiver, send a written memorandum explaining the circumstances to:

Manager, Customer Service
Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34850
Seattle, WA 98124-1850

3.2.3 Process for Resubmission of Claims and Adjustments

To resubmit a claim which was previously returned for correction or clarification, simply attach a copy of the "send-back" letter from the UMP which accompanied the returned original claim and send it with your regular batch of claims.

To request an adjustment to a previously processed claim, network providers should contact the UMP by phone, or write:

Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34850
Seattle, WA 98124-1850

Toll-free..... 1-800-464-0967
Local 425-670-3046

If the UMP agrees that the claim warrants adjustment, the provider may be required to submit the corrected claim with supporting documentation and attach a letter stating the reason that the claim should be adjusted.

The request for review should be no more than 180 calendar days after the original claim was processed. Your request for review will be conducted by an experienced claims examiner who did not process the original claim. If necessary, it will be reviewed by Medical Review staff or the UMP Medical Director.

The decision related to whether or not an adjustment is appropriate will be made within 30 calendar days of receiving the request for review. You will receive notice of the decision in the form of a new DOR with additional payment or a letter from the UMP.

If the adjustment is denied, you may submit a request for further reconsideration (or "Level 2 request") through the process described in Section 8.1.3, Reconsideration.

3.2.4 Enrollee Appeals Procedure for Denied Claims

If a UMP enrollee feels that a claim has been incorrectly processed or payment wrongly denied, it is the responsibility of the enrollee to contact the UMP. Retirees should call 1-800-352-3968; all other enrollees should call 1-800-762-6004. If the problem is not resolved to the satisfaction of the enrollee, he or she may appeal to:

Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34578
Seattle, WA 98124-1578

Details of this process can be found in the current *Certificates of Coverage*.

3.2.5 Audit and Right of Recovery Policy

The UMP's right to audit, inspect, and duplicate records maintained on enrollees by network providers is discussed in the contract between the HCA/UMP and the provider.

Similarly, the UMP's right to seek prompt refund from the provider for any duplicate, erroneous, or excess payments, or to deduct the amount overpaid from future payments, is also discussed in the contract between the HCA/UMP and the provider.

3.2.6 Patients' Rights to Confidentiality

It is the responsibility of the provider to keep audit, billing, payment, medical, and other patient-related information for UMP enrollees confidential, except as necessary for performance of the contract between the HCA/UMP and the provider, unless required by law to do otherwise. A copy of the Notice of Privacy Practices is located on the UMP Web site and hard copy is available on request.

3.2.7 Coordination of Benefits (COB)

Please note that ***Noridian Administrative Services, LLC*** (contracted Medicare carrier/ intermediary) electronically transmits Medicare Part B professional outpatient claims information for Medicare-enrolled UMP enrollees directly to UMP. Therefore, it is not necessary for you or your patients to send UMP paper claims and copies of the Part B Explanation of Medicare Benefits /Medicare Summary Notices from this carrier. For all other claims where UMP is the secondary payer (including Medicare Part A claims and claims from other Medicare carriers/ intermediaries) a copy of the original CMS-1500 claim form along with a copy of the EOB and/ or Detail of Remittance (DOR) provided by the primary payer must be submitted to UMP for secondary payment.

When the UMP PPO is secondary to another group medical insurance plan, reimbursement for services is based on standard coordination of benefits. This means that, after the enrollee's annual deductible has been met, UMP PPO plus the enrollee's other coverage combined pay up to 100 percent of allowed charges (but not more than 100 percent). Usually, enrollees who have UMP PPO as their secondary coverage pay no enrollee cost-share on most claims unless the annual deductible has not been satisfied.

For other services, here's how it works when UMP PPO is not the primary payer:

- The primary payer pays a portion of the bill and sends you an Explanation of Benefits (EOB); you send a copy of the bill and the EOB to UMP PPO;
- UMP PPO reviews the primary plan benefit calculation, and the primary plan payment;
- UMP PPO determines what the normal benefit would have been if UMP PPO had been the only payer;
- UMP PPO compares allowed charges and determines which is the highest allowed charge; and
- UMP PPO pays the difference between the highest allowed charge and the primary plan's payment, up to the normal UMP PPO benefit amount.

Here's an example to illustrate the process and terms above. This example assumes that the primary plan ordinarily pays 80% of allowed charges after a $500 deductible.

Provider's charge	**$1,200**	
Primary Plan Benefit Calculation		
Primary plan's allowed charge:	$1,000	
Primary plan deductible (enrollee pays):	$500	
Primary plan pays:	$400	(80% of $500 balance)
UMP PPO Benefit Calculation		
UMP allowed charge:	$900	
UMP PPO deductible (enrollee pays):	$200	
UMP PPO normal benefit:	$630	(90% of $700 balance)
Actual Payment by UMP PPO		
Highest allowed charge:	$1,000	(primary plan)
Primary plan's payment:	$400	
UMP PPO pays:	***$600***	

3.2.8 Explanation of Benefits (EOB)

When the claim is paid, the patient receives an Explanation of Benefits (EOB) which shows the original submitted charges, any noncovered charges, the patient's responsibility, and the amount that the UMP paid. A sample of the EOB for UMP PPO can be found in Appendix A-2. A sample of the EOB for UMP Neighborhood can be found in Appendix A-6.

The patient's EOB will also indicate when portions of the submitted charge have not been covered because the amount charged exceeds the contracted allowance for the service. The patient is not responsible for these charges and may not be billed for them.

3.2.9 Detail of Remittance (DOR)

Providers will receive a Detail of Remittance (DOR) from the UMP, which will indicate the amount of charges being reimbursed for each claim. A sample of the DOR for UMP PPO can be found in Appendix A-3. A sample of the DOR for UMP Neighborhood can be found in Appendix A-7. The DOR identifies the patient by name and identification number, and identifies the claim number assigned by the claims administrator. Then, for each service line of the claim, the DOR lists the service date, the procedure code of the service, submitted charges, allowed amount, noncovered charges and message code(s), deductible/copay/coinsurance amounts (patient responsibility), network provider discounted amount,and patient balance and amount paid by the UMP. It is recommended that providers not bill the patient for the applicable deductible or coinsurance until after a DOR has been received substantiating reimbursement by the plan.

3.2.10 Service Rebundling Software/DOR Messages

The UMP claims system examines claims and detects coding errors in which a service has been separately billed when that service is clinically considered a part of another service. This type of coding error is called "unbundling." In this situation, separate reimbursement for the bundled service will not be allowed, as it is considered in the UMP payment issued for another reported service. A message indicating that the service has been bundled for payment will appear on the DOR and on the subscriber's EOB. The enrollee is not financially responsible for the separate charges for the "unbundled service."

Section 4

Provider Information

4.1 Provider Requirements

Uniform Medical Plan network providers agree to comply with the following requirements.

4.1.1 Credentialing

Call 206-521-2023 or 1-800-292-8092

- Maintain applicable licensure, registration, and/or certification.
- Maintain professional liability insurance coverage with limits of liability as determined by the HCA/UMP.
- Meet all other credentialing requirements documented in your Network Provider Agreement as determined by the HCA/UMP.
- Accept UMP fee schedules and follow UMP policies and procedures.

4.1.2 Billing

Call 425-670-3046 or 1-800-464-0967

- Bill the UMP no more than your usual and customary fee.
- Submit claims on CMS-1500 claim forms within 60 days after the covered services are rendered. In no instance can a claim be submitted later than 365 days from the date of the covered service(s), except as noted in Section 3.2.2.
- Ensure that enrollees are not billed for any amounts above the maximum allowed charge.
- UMP prefers that the provider collect applicable deductibles and coinsurance from UMP enrollees **after** receiving your detail of remittance documenting the amount the enrollee can be billed as you may not be aware of any deductible or other charges still owed by the enrollee.

4.1.3 Referrals and Authorizations

Call 425-670-3046 or 1-800-464-0967

- Refer enrollees to UMP network providers and network facilities, except where no appropriate network provider is available or in case of an emergency.
- An online provider directory of network providers by city and specialty is available on the UMP Web site at **www.ump.hca.wa.gov**. Network home health and hospice agencies, including infusion therapy providers, are listed in the directory by counties served. The online directory is updated monthly. Non-network providers can apply for network status by contacting the UMP. All providers must meet the UMP selection criteria prior to receiving network provider status. Because the UMP's provider network continues to expand, it is important to verify a provider's network status by contacting UMP Customer Service at 425-670-3046 or 1-800-464-0967 prior to referring patients to that provider.
- Call the UMP to receive preauthorization for those hospital admission diagnoses listed in Section 6.1.2, and to obtain preauthorization for the procedures identified in Section 6.1.3.
- See Section 6 of this manual for detailed information about the UMP utilization review requirements. In addition, see the UMP *Certificate of Coverage*, which outlines other preauthorization requirements, and defines those services that are covered, those that have limitations, and those that are excluded.

Section 5

Enrollee Responsibilities

Patient questions regarding benefits, network provider status, or claims payment? Call 1-800-762-6004 (active employees) or 1-800-352-3968 (retirees).

5.1 Enrollee Requirements

Enrollee education is an important factor in ensuring the timely and appropriate payment of health care benefits. Uniform Medical Plan enrollees are instructed to follow these guidelines when obtaining health care services:

- Choose a provider from the *Network Provider Directory* or the online UMP PPO provider directory at **www.ump.hca.wa.gov**.
- Verify that the services they are obtaining are covered by the UMP by referring to their UMP *Certificate of Coverage*, or by calling the UMP.
- Identify themselves as a UMP enrollee when calling for an appointment.
- Present their identification card at the time services are rendered.
- Remind their physician to refer them to UMP network providers and to admit them to UMP network hospitals.
- Obtain preauthorization from the UMP for:
  - Biofeedback;
  - Cardiac and pulmonary rehabilitation;
  - Cochlear implants;
  - Durable medical equipment for rentals beyond three months or purchases over $1,000;
  - Genetic testing (genetic testing unrelated to pregnancy may be authorized only when performed by a specialist center/provider designated by the UMP);
  - Growth hormones;
  - Home health care in which visits are daily, expected to exceed two hours a day, or length of treatment is expected to last more than 14 consecutive days. Reauthorization is required every two weeks unless determined otherwise by Medical Review. (Please call 1-888-759-4855 prior to the start of home health services in these cases.)
  - Hospice care (in order to be covered at the highest level of benefit);
  - Inpatient admissions for rehabilitation (physical, occupational, speech, and massage therapy);
  - Obstetric services in a birthing center;
  - Obstetric services provided by limited-license providers;
  - Organ transplants, including stem cell and bone marrow;
  - Positron emission tomography (PET) scans;
  - Respite care;
  - Skilled nursing facility admissions;
  - Some prescription drugs (see the UMP Web site at **www.ump.hca.wa.gov** for an up-to-date list of drugs that require preauthorization); and
  - Temporomandibular joint (TMJ) surgery.

  In addition, some frequently prescribed durable medical equipment such as light boxes, hospital beds, and breast pumps, are covered only when they have been determined to be medically necessary. It may be to your patient's benefit to request preauthorization on these items.
- Promptly remit applicable deductibles, coinsurance, copayments, and/or payment for noncovered services.

If your patients have questions regarding benefits, network provider status, or payment of their claims, please refer them to the UMP at the above-referenced numbers.

Section 6

Utilization Review

Prenotification/preauthorization questions? Call 425-670-3046 or 1-800-464-0967.

6.1

Utilization Review Requirements

6.1.1 Overview

The UMP Medical Review professionals perform utilization and quality review, as well as case management services for our enrollees.

For preauthorization and prenotification services or information related to eligibility, call the numbers at the beginning of this section.

The UMP's utilization management program includes review of certain medical services before, during, and after they are delivered. Reviews are conducted for:

- Optional case management (selected complex or high-expense cases);
- Prenotification for certain diagnoses;
- Required case management; and
- Retrospective (postpayment) review.

The purpose of the review is to determine whether or not services are medically necessary and delivered in the most appropriate setting. Such reviews help to:

- Monitor quality of care;
- Ensure that treatment is necessary and consistent with good medical practices;
- Discourage unnecessary care;
- Save health care dollars; and
- Identify chronic and catastrophic cases appropriate for case management.

6.1.2 Prenotification

The purpose of this program is to allow the UMP the earliest possible identification of patients for whom case management services may be appropriate.

When a UMP enrollee is admitted to the hospital for one of the diagnoses identified below, the UMP must be notified. This allows for screening of potential case management cases and initiation of case management when indicated.

Diagnoses requiring prenotification include:

- Cancer
- Chemical dependency
- Chronic respiratory disease
- Congenital defects
- Congenital heart disease
- CVA (cerebrovascular accident/stroke)
- Diabetes
- HIV disease
- Ischemic heart disease/peripheral vascular disease
- Neonatal complications
- Neurodegenerative disorders (multiple sclerosis, amyotrophic lateral sclerosis, muscular dystrophy)
- Organ transplant, including stem cell and bone marrow
- Pregnancy (complications of)
- Spinal cord injury
- Trauma (multiple trauma, head injury)

Any hospital stay exceeding 10 days must be reported to the UMP.

Prenotification is not required when Medicare or another benefit plan requiring prior notification/preauthorization is the primary payer.

Note: The prenotification process does not involve approval for medical necessity or preauthorization of services. These admissions may be subject to retrospective (postpayment) review.

6.1.3 Preauthorization

To ensure that standard benefits are received by the enrollee, prior authorization by the plan must be received before you render the following services:

- Biofeedback.
- Cardiac and pulmonary rehabilitation.
- Cochlear implants.
- Durable medical equipment for rentals beyond three months or purchases over $1,000.

- Genetic testing (genetic testing unrelated to pregnancy may be authorized only when performed by a specialist center/provider designated by the UMP).
- Growth hormones.
- Home health care in which visits are daily, expected to exceed two hours a day, or length of treatment is expected to last more than 14 consecutive days. Reauthorization is required every two weeks unless determined otherwise by Medical Review. (Please call 1-888-759-4855 prior to the start of home health services in these cases.)
- Hospice care (in order to be covered at the highest level of benefit).
- Inpatient admissions for rehabilitation (physical, occupational, speech, and massage therapy).
- Obstetric services in a birthing center.
- Obstetric services provided by limited-license providers.
- Organ transplants, including stem cell and bone marrow.
- Positron emission tomography (PET) scans.
- Respite care.
- Skilled nursing facility admissions.
- Some prescription drugs (see the UMP Web site at **www.ump.hca.wa.gov** for an up-to-date list of drugs that require preauthorization).
- Temporomandibular joint (TMJ) surgery.

In addition, some frequently prescribed durable medical equipment such as light boxes, hospital beds, and breast pumps, are covered only when they have been determined to be medically necessary. It may be to your patient's benefit to request preauthorization on these items.

See the UMP *Certificate of Coverage* for specific information on preauthorization requirements and scope of coverage of these benefits.

6.1.4 Requirements for Skilled Nursing Facilities (SNF)– Medicare-Approved Only

Medical review is required for skilled nursing facility admissions prior to payment. To request preauthorization, call the UMP at the numbers at the beginning of this section.

Medical review is not required when Medicare or another benefit plan that requires preauthorization is the primary payer and is providing benefits. If Medicare or another benefit plan is denying coverage, or Medicare limits have been exceeded, medical review will be required by the UMP.

At the time of medical review or preauthorization, all cases will be screened for referral to Case Management.

6.1.5 Case Management

6.1.5.1 Optional Case Management

Case management is a collaborative process which may include a UMP nurse case manager coordinating with hospitals, skilled nursing facilities, or other facilities by telephone or on-site visits. This will require the cooperation of the facility and the attending physician.

Generally, cases are identified as candidates for case management through the prenotification process. However, a facility or provider may suggest other patients with chronic or catastrophic illnesses for referral to case management. In this instance, the facility or provider should call 1-888-759-4855 to speak to a nurse case manager (see Section 6.1.2).

6.1.5.2 Required Case Management

The UMP Medical Director or his delegate may review an enrollee's medical records and evaluate whether the enrollee's use of medical services is unsafe, potentially harmful, excessive, or medically inappropriate. Based on this review, the UMP may require an enrollee to participate and comply with a case management plan as a condition of continued payment for services under the UMP.

Among other services, case management often includes designating a primary provider to coordinate care, and designating a single hospital and pharmacy to provide covered services or medications. The UMP has the right to deny payment for any services received outside the required case management plan with the exception of medically necessary emergency services provided outside the service area.

6.1.6 Retrospective Review

Certain admissions and services may be subject to retrospective (postpayment) review. This process involves an assessment of the:

- Medical necessity of the admission and/or procedure(s) performed;
- Appropriateness of the treatment setting or length of treatment;
- Patient's status upon discharge;
- DRG validation;
- General quality of care delivered; and
- Validation of the procedure(s) and diagnoses codes submitted.

Providers and facilities are responsible for supplying any requested medical records or documentation required to complete these reviews. Failure to comply with such requests may result in denial of benefits.

6.1.7 Review Criteria and Quality Screens

The UMP professional staff use multiple resources, including Medicare coverage criteria, payment policies, and manuals; and other national guidelines when conducting case reviews. In the majority of cases, UMP follows Medicare coverage and billing guidelines. If the nurse determines that a case does not meet the review criteria, the case will be referred to the UMP Medical Director. The decision to approve or deny is made by the UMP Medical Director after consultation with the attending physician, when appropriate, and is based on medical experience and expertise.

Section 7

Payment Rules

Questions? Call 425-670-3046 or 1-800-464-0967.

7.1

General Information

7.1.1 UMP PPO *Certificate of Coverage*

The UMP PPO *Certificate of Coverage* (COC) (available on the UMP Web site at **www.ump.hca.wa.gov** or by calling 1-800-762-6004) is the official source of plan benefits and scope of coverage information. Throughout this section of the billing manual, key information from the COC that is pertinent to the benefit under discussion may be referenced for the provider's information. **Providers must rely on the COC itself to obtain full and complete information regarding the scope of coverage and benefit provisions.** Refer to the "How the UMP Works" section of the COC for a listing of provider types approved to deliver services.

7.1.2 Plan Payment Provisions for Providers

Unless otherwise specified in this manual, the enrollee's applicable calendar year deductible must be satisfied before the plan will make a payment for services provided under a given benefit.

Services exempt from the annual medical/surgical deductible include:

- Preventive care*;
- Retail and mail-order prescription drugs**;
- Routine vision exams and hardware;
- Required second surgical opinions; and
- Tobacco cessation services provided through the *Free & Clear* smoking cessation program.

* The UMP follows the preventive care guidelines established by the U.S. Preventive Services Task Force (USPSTF) when determining coverage for preventive care. See Section 7.2.2, Preventive Care, for more information.

**The UMP has a separate annual deductible for prescription drugs. It is a combined retail and mail-order deductible. See the UMP *Certificate of Coverage* for more details.

In the UMP PPO *Certificate of Coverage* and elsewhere, "non-network" and "out-of-network" refer to services from providers who are not contracted with UMP PPO. "Non-network" is usually used to refer to situations where the enrollee had the opportunity to use a UMP PPO provider but chose not to. "Out-of-network" refers to situations where the enrollee did not have access to a network provider, as determined by UMP. After the enrollee's annual medical/surgical deductible has been met, the plan's payment provisions generally are as follows:

- For **network providers (in Washington, Oregon, and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce)**, the plan pays 90 percent of the allowable amount. (The "allowable amount" is the actual charge or the fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 10 percent. (**Note:** A payment differential applies to certain categories of providers. This differential is described in the following section.)
- For **non-network providers and out-of-network providers**, the plan pays a lower percentage of the allowable amount. (The "allowable amount" is the actual charge or the fee schedule amount in Washington, whichever is less. In all other states, the allowable is based on a regionally adjusted charge.) When using a non-network or out-of-network provider, the enrollee is responsible for a higher coinsurance amount as well as any outstand-

ing balance above the plan's allowable amount. Refer to the UMP *Certificate of Coverage* for specific details regarding the payment provisions, plan benefits, and scope of coverage.

For network and out-of-network providers, these payment provisions are in effect until the out-of-pocket limit or benefit limit is reached. However, even if the enrollee's out-of-pocket limit is reached, out-of-network providers can still balance bill enrollees for the difference between the billed and allowed charges. For services from non-network providers, the annual out-of-pocket limit does not apply and the payment provisions above are in effect until the enrollee's lifetime maximum benefit limit is reached. Inpatient services are subject to the inpatient hospital copayments or coinsurance. For additional details regarding payment provisions, plan benefits and scope of coverage, see the UMP PPO *Certificate of Coverage*.

Note: *Through the Beech Street network (see directory at* **www.beechstreet.com***), UMP enrollees also have access to network providers outside of Washington, Oregon, and other Idaho counties. However, covered services from Beech Street network providers in these other states are generally reimbursed at 80% of allowed charges.*

Also note: Services rendered under private contracts by providers who "opt out" of the Medicare program will not be covered or reimbursed by the UMP. Exceptions are services provided on an emergency/urgent basis or that are excluded under the Medicare program, such as routine eye exams and preventive care services/procedures, which will be processed and paid according to UMP benefits. In a private contract situation, the UMP enrollee is solely responsible for the provider's total billed charges.

7.1.3 Payment Differential Policies

7.1.3.1 Provider Type Payment Differentials

A payment differential applies to services rendered by certain categories of providers. The plan allowable amount for covered services provided by the following providers is the lesser of the provider's actual charge or 90 percent of the applicable UMP *Professional Provider Fee Schedule* amount.

- Certified nurse midwives
- Licensed midwives
- Licensed advanced registered nurse practitioners
- Licensed masters of social work (LMSW)
- Licensed mental health counselors (LMHC)
- Licensed marriage and family therapists (LMFT)
- Licensed physician assistants (PA)*

The plan allowable amount for covered services provided by the following provider is the lesser of the providers' actual charge or 80 percent of the applicable UMP *Professional Provider Fee Schedule* amount.

- Licensed certified registered nurse first assistants (CRNFA)**

Enrollee cost-sharing provisions then apply to the above-referenced provider's allowable amount.

* The employer (physician or physician clinic/group) must bill services provided by licensed Physician Assistants (PAs) for UMP coverage and payment consideration, as the UMP does not credential or reimburse PAs directly. The CMS-1500 claim form must include the employer's tax I.D. number in field 25, PA's name in field 31, and the employer's name/address in field 33.

** Services provided by CRNFAs are covered only where an assistant at surgery is payable by the plan. For payment consideration, the CRNFA's services must be billed by the supervising physician. The UMP will not reimburse CRNFAs directly at any time. The CMS-1500 claim form must include the supervising physician's tax I.D. number in field 25, the CRNFA's name in field 31, and the supervising physician's name/address in field 33.

Note: the UMP will not cover any services provided by an RNFA who is not certified.

Refer to the UMP *Certificate of Coverage* for payment provisions and specific details on plan benefits and scope of coverage.

Please note: Payment differentials for the categories of providers stated in this section may be subject to change based on CMS guidelines.

7.1.3.2 Site of Service Payment Differentials

The UMP applies a site of service payment differential based on CMS's dual resource-based practice expense relative value units (RVUs) and Medicare payment policy. The resource-based relative value scale (RBRVS) maximum allowances on the UMP *Professional Provider Fee Schedule* are determined using CMS's three RVU components (work, practice expense, and malpractice expense).

With two levels of practice expense RVUs for many procedure codes, the UMP *Professional Provider Fee Schedule* contains distinct maximum allowances for reimbursement of professional services performed in both facility and non-facility settings. There are:

- Facility setting maximum allowances, which apply when the professional services are performed in a facility setting and the cost of the resources are the responsibility of the facility; or
- Non-facility setting maximum allowances, which apply when the provider performing the services typically bears the overhead expenses and resource costs, such as labor, medical supplies, and medical equipment associated with the services performed.

The non-facility setting maximum allowances are used to reimburse professional services performed in all settings, except for the following settings where a separate payment is issued for facility charges: ambulances, ambulatory surgery centers (ASC)*, licensed birthing centers, community mental health centers, hospice facilities, hospitals, Indian health facilities, military facilities, skilled nursing facilities, and tribal facilities. In these settings, the facility setting maximum allowances, which exclude the allowance for facility overhead expenses and resource costs, are used to reimburse professional services.

UMP does not provide separate payment for facility charges when the non-facility setting maximum allowances are used, such as for services performed in physician offices and surgical suites. UMP reimburses for these expenses within the practice expense component of the non-facility setting maximum allowance for the professional service, which includes facility overhead costs.

* An ASC facility must be licensed by the state(s) in which it operates, unless that state does not require licensure. In addition, the facility must be Medicare-certified or be accredited by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or have accreditation as an ASC by another national accrediting organization recognized by UMP.

Some services, by nature of their description, are performed only in certain settings and have only one maximum allowable fee per code. Examples of these services include many evaluation and management codes, which specify the site of service within the description of the procedure codes; and major surgical procedures that are generally performed only in hospital settings.

Please note: Following Medicare's consolidated billing requirements, the UMP does not make a separate payment to the performing provider for therapies (such as physical therapy, occupational therapy, and speech therapy) provided in hospitals or skilled nursing facilities. In these settings, the facilities must submit a consolidated bill for the therapies provided. Since a single payment is issued to the facility only, UMP reimbursement for the therapies to the facilities is based on the non-facility setting maximum allowable fees, which include facility overhead expenses and resource costs.

Professional claims without a valid CMS 2-digit place of service code will be denied. Refer to Section 3 of this manual for a list of the place of service codes.

7.1.4 Patient's Financial Responsibility

The patient cannot be billed for:

- Any amounts above the UMP allowed amount;
- Any amount for which the UMP is responsible; or

- Any services that UMP determines is not or was not medically necessary. An exception to this requirement is made if the patient understood, prior to receiving the service(s), that the service(s) would not be covered by the UMP, and agreed in writing to assume financial responsibility for the service(s).

Except as provided above or in the contract, the patient can be billed for:

- Any applicable deductible or coinsurance; or
- Any charges for UMP-excluded services.

UMP prefers that the provider collect applicable deductibles and coinsurance from UMP enrollees after receiving the detail of remittance documenting the amount the enrollee can be billed.

7.1.5 Modifiers

7.1.5.1 Modifiers That May Affect Payment

Only valid CPT and HCPCS level II modifiers should be used when billing the UMP for provider services. The following modifiers may affect payment for UMP claims. While other valid CPT and HCPCS level II modifiers may be used for informational purposes, they do not affect payment. Modifiers for anesthesia services can be found in Section 7.10.

Description of Modifier	
22	Unusual services
24	Unrelated evaluation and management (E&M) services by the same physician during a postoperative period
25	Significant, separately identifiable E&M service by the same physician on the same day of a procedure or other service
26	Professional component
50	Bilateral procedure
51	Multiple procedures
54	Surgical care only
55	Postoperative management only
56	Preoperative management only
57	Decision for surgery
58	Staged or related procedure or service by same physician during the postoperative period
59	Distinct procedural service
62	Two surgeons
66	Surgical team
78	Return to O.R. for related procedure during postoperative period
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant surgeon (when qualified resident surgeon not available)
99	Multiple modifiers which may affect payment
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
TC	Technical component

These modifiers are explained in more detail under the appropriate service headings on the following page.

7.1.5.2 Requirements for Submission of Supporting Documentation for Modifiers

All claims with modifiers **-22, -51, -62, and -66** are individually reviewed prior to payment.

An operative report and/or other supporting documentation must be submitted with the claim for review when submitting modifier **-22**.

When modifier **-51** is used and more than five procedures are reported, supporting documentation is required with the incoming claim. When fewer than five procedures are reported, the operative report and/or other supporting documentation is not required with the incoming claim, but may be requested if needed during the payment review.

For claims with modifiers **-62** and **-66** the operative report and/or other supporting documentation is not required with the incoming claim, but may be requested if needed during the payment review.

Supporting documentation (including medical records) for using other modifiers (such as modifier **-25** and **-59**) is required only if requested by UMP or the claims administrator.

7.1.6 Documentation Requirements for Unlisted Procedures

All claims with unlisted CPT and/or HCPCS level II codes must be accompanied by supporting documentation**.** Unlisted codes generally end with "99" or "9" in the last digits of the CPT code. Supporting documentation for the different categories of services is defined as follows.

Type of Unlisted Service	Unlisted CPT Codes Within This Range	Type of Supporting Documentation
Surgical procedures	15999 to 69979	Operative report
Radiology	76496 to 79999	Clinic or office notes, x-ray report, and/or written description on or attached to the claim
Laboratory	80299 to 89399	Laboratory or pathology report and/or written description on or attached to the claim
Medical	90399 to 99199 and 99600	Written description on or attached to the claim
Evaluation and management	99429, 99499, and 99600	Daily office notes and/or written description on or attached to the claim
Drugs and biologicals (administered by the professional provider)	J3490 – J9999	Name, manufacturer, strength, dosage, and quantity of the drug. If there is a specific drug code available, it should be used instead of an unclassified or unspecified drug code. **Note**: Codes J8499 and J8999 for oral drugs are generally not covered.

Unlisted HCPCS level II codes can be identified when the following terms are used to define them: "Unlisted, not otherwise classified (NOC), unspecified, unclassified, other, and miscellaneous." Use the appropriate unlisted procedure code, and provide a written description of the item or service on or attached to the claim.

7.2

Medical Visits and Consultations

7.2.1 Office, Clinic, and Hospital Visits

All office, hospital, clinic, skilled nursing facility, and home visits by approved provider types for the diagnosis or treatment of covered conditions are covered under this benefit, subject to any specific plan limitations on the services being provided. Please refer to the UMP *Certificate of Coverage* for details regarding the scope of coverage of these benefits.

7.2.2 Preventive Care

Routine physical exams as recommended by the U.S. Preventive Services Task Force (USPSTF) *Guide to Clinical Preventive Services* are covered by the UMP. UMP preventive care benefits include screening mammograms, well-baby care, and other services provided specifically to monitor and maintain the patient's health and/or prevent illness. The benefit is based on recommendations of the U.S. Preventive Services Task Force as well as the National Immunization Program of the Centers for Disease Control and Prevention, and recently published peer-reviewed literature on preventive care. Refer to the *Certificates of Coverage* for more details on specific preventive care benefits.

When preventive care services are provided, the services must be coded as such for coverage/payment consideration under the UMP preventive care benefit.

Preventive medicine E&M services must be reported with the applicable CPT procedure code (i.e., 99381–99397). When an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing the preventive E&M service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, providers may report the applicable CPT office/outpatient E&M code (i.e., 99201–99215) in addition to the applicable preventive medicine E&M code for coverage/payment consideration. In this situation modifier -25 must be reported with the office/outpatient E&M code to indicate that a significant separately identifiable E&M service was provided.

A separate charge for an office/outpatient E&M code is not appropriate if an insignificant or trivial problem/abnormality is encountered during the preventive care visit that does not require additional work and performance of the key components of a problem-oriented E&M service.

When it is appropriate to bill both procedure codes, the preventive medicine E&M code will be paid according to the full UMP fee schedule amount and the office/outpatient medical E&M code will be paid according to a reduced rate that is based on the RVU work value only.

For additional coding information for preventive medicine E&M services, please refer to the current CPT book.

Please be prepared to provide supporting documentation if requested. Medically unnecessary services are considered provider liability under the UMP Network Provider Contract. Charges for preventive care services provided under the terms of this benefit are exempt from the enrollee's calendar year deductible. Except as described above, if a medical diagnosis is billed in addition to preventive medical services, the claim will not be processed as a preventive service and the enrollee's annual deductible and coinsurance may apply.

Coverage of routine vision care is discussed under the "Vision Care" section of the UMP *Certificate of Coverage*.

7.2.3 After Hours, Evening, and Holiday Services

After hours services (CPT® codes 99050–99054) will only be considered for separate payment when:

- The provider's office is not regularly open; and
- The after hours services code is billed with an appropriate evaluation and management service.

Only one after hours service code will be reimbursed per patient per day. After hours service codes are

not payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists, and laboratory clinical staff. The medical necessity and urgency of the service must be documented in the medical records and be available upon request.

7.2.4 Physician Team Conferences and Phone Consultations, Physician Standby Service, and Prolonged Evaluation and Management (E&M) Services

7.2.4.1 Physician Team Conferences and Physician Phone Consultations

CPT codes 99361, 99362, 99371, 99372, and 99373 must be documented as medically necessary in the medical record. These procedures are not separately reimbursable if they result from, result in, or otherwise relate to another procedure billed by the same provider.

7.2.4.2 Physician Standby Service

CPT code 99360 is used to report physician standby services requested by another physician that involve prolonged physician attendance without direct (face-to-face) patient contact. Please note the following guidelines for billing CPT code 99360.

- The standby physician may not provide care to other patients during the period.
- CPT code 99360 is not used to report time spent proctoring another physician.
- CPT code 99360 is not reimbursable when the standby period ends with the performance of a procedure subject to a "surgical package" by the physician who was on standby.
- CPT code 99360 is not reimbursable when billed in addition to any other procedure code, with the exception of CPT codes 99291, 99292, 99431, or 99440, on the same day.
- CPT code 99360 is used to report the total duration of time spent. Standby of less than 30 minutes is not reimbursed by the UMP under any circumstances.
- Subsequent periods of standby beyond the first 30 minutes may be reported and are reimbursable only when a full 30 minutes of standby was provided for each unit of service reported. All fractions of a 30-minute time unit must be rounded downward.
- Claims for physician standby service must be accompanied by medical records at the time of submission to the UMP.

7.2.4.3 Prolonged Evaluation and Management (E&M) Services

Payment of prolonged E&M codes (99354-99357) is allowed with a maximum of three hours per day per patient**.** The physician must be providing prolonged services involving direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting. These services are payable only when another E&M code is billed on the same day using the following CMS payment criteria:

Code	Other Code(s) Required on Same Day
99354	99201 to 99205, 99212 to 99215, or 99241 to 99245
99355	99354 *and* one of the E&M codes required for 99354
99356	99221 to 99223, 99231 to 99233, 99251 to 99255, 99261 to 99263, 99301 to 99303, or 99311 to 99313
99357	99356 *and* one of the E&M codes required for 99356

The time counted toward payment for prolonged E&M services includes only direct face-to-face contact between the physician and the patient (whether the service was continuous or not). Physicians may not include time that a patient spends occupying an exam or treatment room while there is no direct contact between physician and patient, or time spent with a nonphysician "incident to a physician's service."

7.2.5
Modifiers for Evaluation and Management Services

Evaluation and management (E&M) services provided as part of a global package are generally included in the reimbursement of the procedure and are not separately reimbursable. However, the modifiers listed below identify services that are reimbursed separately if requirements are met. Supporting documentation such as medical records must be submitted to the UMP upon request.

Description of Modifier

24 **Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period**

This modifier is used to indicate that an evaluation and management service was performed during a postoperative period that is not related to the surgical procedure.

25 **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service**

This modifier is used to indicate that, on the day of a procedure, a significant, separately identifiable related or unrelated E&M service was required due to the patient's condition.

57 **Decision for Surgery**

This modifier indicates that the decision to operate was made during this E&M visit and separate payment should be made, even if the visit falls within the global surgery period.

7.3

Surgery

7.3.1 Surgical Services

Covered services under this benefit include those provided by the surgeon, assistant surgeon*, licensed physician assistant*, certified registered nurse first assistant*, and anesthesia provider in performing medically necessary surgery for a covered condition. Please refer to the UMP *Certificate of Coverage* for details regarding the scope of coverage of these benefits.

* When deemed medically necessary in the opinion of the plan.

7.3.2 Global Surgery Rules

The UMP follows Medicare's national definition of a global surgical package, in which a single fee is billed and paid for all necessary services, normally furnished by the surgeon before, during, and after the procedure. Under the payment policy, major procedures have a 90-day postoperative period. Minor surgeries and endoscopies have a 0- or 10-day postoperative period. The UMP payment policy differs from Medicare's by having a 45-day post-operative period for some maternity care and delivery codes. The applicable global day period for each procedure code is included on the UMP *Professional Provider Fee Schedule*, which can be downloaded from the UMP Web site at **www.ump.hca.wa.gov**. Surgical procedures are reimbursed according to the UMP fee schedule based on the RBRVS methodology.

The global surgery definition includes:

- The operation;
- Preoperative visits, in or out of the hospital, beginning on the day prior to surgery;
- Services by the primary surgeon, in or out of the hospital, during a standard postoperative period as described above;
- Dressing changes; local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral IV lines, and nasogastric and rectal tubes; and change and removal of tracheostomy tubes; and
- All additional medical or surgical services required because of complications that do not require additional trips to the operating room.

The global surgery definition does not include the initial evaluation, consultation, or preoperative visits prior to the day before surgery. Also excluded are postoperative visits for problems unrelated to the surgery or for services that are not included in the normal course of treatment for the surgery.

For endoscopic procedures and minor surgery where global surgical payment policy does not usually apply, payments are denied for an E&M service on the same day of the surgical or endoscopic procedure unless a documented, separately identifiable service is provided.

Claims for services that may be separately payable within the preoperative or postoperative period of a procedure must include the appropriate diagnosis codes and applicable procedure modifier (such as -24, -25, -57,-59 -76, -77,-78, or -79) for payment consideration. Supporting documentation must be provided to the UMP upon request.

Please refer to Section 7.4 for information regarding the bundling of payment for supplies, surgical trays, and services provided in the physician's office.

7.3.3
Modifiers for Surgical Procedures

The UMP follows Medicare's pricing rules for the CPT surgical modifiers listed below.

Surgical Modifier

50 Bilateral Procedure

The bilateral modifier identifies cases where a procedure typically performed on one side of the body is, in fact, performed on both sides of the body. For surgical procedures typically performed on one side of the body that are, in a specific case, performed bilaterally, the maximum allowance is 150 percent of the global surgery fee schedule amount for the procedure. Providers must bill using the single procedure code with modifier -50.

51 Multiple Procedures

Multiple Surgeries: If multiple procedures are performed on the same patient at the same operative session or on the same day, the total maximum allowance is equal to the sum of the following: One hundred (100) percent of the global fee schedule amount for the highest fee-schedule-valued procedure and fifty (50) percent of the global fee schedule amount for the second through fifth procedures. Surgical procedures in excess of five require submission of supporting documentation and individual review to determine payment amount. ***Multiple Endoscopies:*** Related endoscopic procedures performed on the same day are subject to the multiple endoscopy rule. The maximum allowance for the procedure with the highest fee schedule value is the full fee schedule amount. The maximum allowance for the second procedure is the full fee schedule amount minus the fee schedule amount for its base diagnostic endoscopy procedure. Unrelated endoscopic procedures performed on the same day are subject to the regular multiple surgery rule instead of the multiple endoscopy rule, since the codes are not in the same procedure family. The maximum allowance for the procedure with the highest fee schedule value is the full fee schedule amount, and the second procedure is allowed at 50 percent of the fee schedule amount.

If multiple related endoscopies (e.g., upper and lower gastrointestinal endoscopies), are performed on the same day, the special multiple endoscopy rules are applied separately within each group, and the multiple surgery rules are applied between groups.

Please note: Providers should not discount their billed charges for multiple procedures. The appropriate discount as indicated above is applied to the maximum allowances by the UMP.

54, 55, & 56 Providers Furnishing Less than the Global Surgical Package

These modifiers are designed to ensure that the sum of all maximum allowances for all practitioners who furnished parts of the services included in a global surgery fee schedule allowance do not exceed the total amount that would have been allowed to a single practitioner. The payment policy pays each provider directly for the portion of the global surgery services furnished to the enrollee. The UMP follows CMS's pre-, post-, and intraoperative percentages as published in the *Medicare Physician Fee Schedule Data Base*. For split-care, there must be an agreement for the transfer of care between the surgeon and provider who will provide pre- and/or postoperative care. Postoperative care is paid according to the number of days each provider is responsible for the patient's care and must be agreed upon by each provider so each provider bills the correct number of days. The three modifiers used are:

54 Surgical Care Only

This modifier is used by the surgeon when he/she is performing only the preoperative and intraoperative care. Payment is limited to the amount allotted to the preoperative and intraoperative services.

55 Postoperative Management Only

This modifier must be used when a provider other than the operating surgeon assumes responsibility for the postoperative care of the patient. When submitting charges, the same CPT code that the surgeon used should be billed with modifier 55. The postoperative care is paid at a percentage of the physician's fee schedule. The receiving provider cannot bill for any part of the service included in the global period until he/she provides at least one service. The receiving provider must bill postoperative care as one lump sum.

56 Preoperative Management Only

This modifier is used by a provider who performs the preoperative care and evaluation and who is not the operating surgeon. Payment is limited to the amount allotted to the preoperative services.

58 Staged or Related Procedure or Service by Same Physician During the Postoperative Period

This modifier is used when a surgical procedure is performed during the postoperative period of another surgical procedure because the subsequent procedure: a) was planned at the time of the original procedure; b) was more extensive than the original procedure; or c) was for therapy following a diagnostic surgical procedure.

62 Two Surgeons

For surgery requiring the skills of two surgeons (each with a different specialty), the maximum allowance for each surgeon is 62.5 percent of the global surgical fee schedule amount. No payment is made for an assistant-at-surgery in these cases.

66 Team Surgery

This modifier is used when highly complex procedures are carried out by a surgical team, which may include the concomitant services of several physicians, often of different specialties; other highly skilled, specially trained personnel; and various types of complex equipment. Procedures with this modifier are reviewed and priced on an individual basis. **Supporting documentation may be requested for this review**.

76 Repeat Procedure by Same Physician

This modifier is used to indicate that a procedure or service was repeated subsequent to the original procedure or service.

77 Repeat Procedure by Another Physician

This modifier is used to indicate that a procedure or service performed by another physician had to be repeated.

78 Return to O.R. for Related Surgery During Postoperative Period

Use of this modifier allows separate payment for procedures associated with complications from surgery. The maximum allowance is limited to the amount allotted for intraoperative services only.

80, 81, 82, & AS Assistant-at-Surgery

Four modifiers may be used to identify procedures where a second provider assists another in the procedure. They are:

80 - Assistant Surgeon
81 - Minimum Assistant Surgeon
82 - Assistant Surgeon (when qualified resident surgeon is not available)
AS - Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery.
Note: "AS" is also the appropriate modifier for certified registered nurse first assistant claims.

The maximum allowance for procedures with these modifiers is the lower of the following:

- Actual charge; or
- Twenty (20) percent of the global surgery fee schedule amount for the procedure.

Multiple surgery rules apply to subsequent multiple procedures.

Provider payment differentials described in Section 7.1.3 of this manual apply to maximum allowances for services reported with modifier AS.

Other Related Modifiers

22 Unusual Services

Procedures with this modifier are individually reviewed prior to payment. An operative report and/or other supporting documentation must be submitted with the claim for review.

24 Unrelated Evaluation and Management (E&M) Services by the Same Physician During a Postoperative Period

This modifier is used to indicate that an evaluation and management service was performed during a postoperative period that is not related to the surgical procedure. Supporting documentation may be requested for review.

25 Significant, Separately Identifiable Evaluation and Management (E&M) Service by the Same Physician on the Same Day of a Procedure or Other Service

This modifier is used to indicate that, on the day of a procedure or other service, a significant, separately identifiable, related or unrelated E&M service was required due to the patient's condition. Supporting documentation may be requested for review.

59 Distinct Procedural Service

This modifier is used to indicate that a procedure or service was distinct or independent from other services performed on the same day. Supporting documentation may be requested for review.

99 Multiple Modifiers

Under certain circumstances, two or more modifiers may be necessary to completely delineate a service. For procedures where more than two modifiers which affect payment apply, modifier "99" should be added to the base procedure and other applicable modifiers listed as part of the service description. The claim is individually reviewed prior to payment. Supporting documentation may be requested for review.

7.4

Bundled Surgical Trays, Supplies, and Services

Services and supplies provided under this benefit must be medically necessary and must be prescribed by an approved provider type for the direct treatment of a covered condition. Please refer to the UMP *Certificate of Coverage* for details regarding the scope of coverage of these benefits.

7.4.1 Surgical Trays Used in the Provider's Office

The UMP does not provide separate payment for surgical trays reported under HCPCS code A4550. With the implementation of CMS's resource-based practice expense relative value units and payment policy, the reimbursement for surgical trays is included in the UMP payment for the procedure. Refer to Section 7.4.2 for information on bundled supplies.

The UMP *Billing & Administrative Manual* contains abbreviated definitions of procedure codes. For billing purposes, please refer to the most current edition of the CPT and HCPCS books for complete descriptions of the procedure codes.

7.4.2 Bundled Supplies

Under the UMP fee schedule RBRVS methodology, many supply items are considered "bundled" into the cost of other services (associated office visits or procedures), and are not paid separately.

Please note: Items with an asterisk (*) on the following list are considered prosthetics when used for a permanent condition and may be paid separately for permanent conditions if they are provided in the physician's office. They are not considered prosthetics if the condition is acute or temporary. Examples are Foley catheters and accessories for permanent incontinence, or ostomy supplies for permanent conditions. A catheter used to obtain a urine specimen after surgery, or a Foley catheter used to treat an acute obstruction would not be paid separately because they are treating a temporary problem. If a patient had an indwelling Foley catheter for permanent incontinence, and a problem developed which required the physician to replace the Foley, then the catheter would be considered a prosthesis and would be paid separately.

Items with two asterisks (**) on the following list are surgical dressings that are not separately reimbursable when applied by a provider during the course of a procedure or an office visit. The cost for the surgical dressings is included in the practice expense component of the relative value unit for the professional service. Primary and secondary surgical dressings dispensed *for home use* are reimbursed separately when billed with place of service "12" (home).

Bundled supplies that are not paid separately are listed below.

Bundled Supplies

Code	Brief Description
99070	Special supplies
A4206	Syringe with needle, sterile 1 cc
A4207	Syringe with needle, sterile 2 cc
A4208	Syringe with needle, sterile 3 cc
A4209	Syringe with needle, sterile 5 cc
A4211	Supplies for self-administered injections
A4212	Non-coring needle or stylet
A4213	Syringe; sterile, 20 cc or greater
A4214	Sterile saline or water, 30 cc (Deleted 2004 code not valid for dates of service after 3/31/04)
A4215	Needles only, sterile, any size
A4216	Sterile water/saline, 10 ml
A4217	Sterile water/saline, 500 ml
A4220	Refill kit for implantable infusion pump
A4244	Alcohol or peroxide
A4245	Alcohol wipes
A4246	Betadine or pHisoHex solution

Bundled Supplies

Code	Brief Description
A4247	Betadine or iodine swabs/wipes
A4248	Chlorhexidine antisept
A4253	Blood glucose test or reagent strips for home glucose monitor
A4256	Normal, low, and high calibrator solution/chips
A4258	Spring-powered device for lancet
A4259	Lancets
A4262	Temporary absorbable lacrimal duct implant
A4263	Permanent tear duct plug
A4265	Paraffin
A4270	Disposable endoscope sheath
A4300	Cath impl vasc access portal
A4301	Implantable access total system; catheter, port/ reservoir, percutaneous access
A4305	Disposable drug delivery system, flow rate 50 ml or more per hour
A4306	Disposable drug delivery system, flow rate 5 ml or less per hour

Bundled Supplies

Code	Brief Description
A4310	Insertion tray without drainage bag
A4311	Insertion tray without drainage bag
A4312	Insertion tray without drainage bag
A4313	Insertion tray without drainage bag
A4314	Insertion tray with drainage bag
A4315	Insertion tray with drainage bag
A4316	Insertion tray with drainage bag
A4319	Sterile H_2O irrigation solut (Deleted 2004 code not valid for dates of service after 3/31/04)
A4320	Irrigation tray with bulb or piston syringe
A4322	Irrigation syringe, bulb, or piston
A4323	Sterile saline irrigation solution (Deleted 2004 code not valid for dates of service after 3/31/04)
A4324	Male ext cath w/adh coating*
A4325	Male ext cath w/adh strip*
A4326	Male external catheter*
A4327	Female external urinary collection*
A4328	Female external urinary collection*
A4330	Peri-anal fecal collection pouch
A4331	Extension drainage tubing*
A4332	Lubricant for cath insertion*
A4333	Urinary cath anchor device*
A4334	Urinary cath leg strap*
A4335	Incontinence supply, miscellaneous*
A4338	Indwelling catheter, Foley type*
A4340	Indwelling catheter, specialty type*
A4344	Indwelling catheter, Foley type*
A4346	Indwelling catheter, Foley type*
A4347	Male external catheter*

Bundled Supplies

Code	Brief Description
A4351	Intermittent urinary catheter
A4352	Intermittent urinary catheter
A4353	Intermittent urinary catheter, with insertion supplies
A4354	Insertion tray with drainage bag
A4355	Irrigation tubing set
A4356	External urethral clamp device*
A4357	Bedside drainage bag, day or night*
A4358	Urinary leg bag, vinyl*
A4359	Urinary suspensory without leg bag*
A4361	Ostomy faceplate*
A4362	Skin barrier; solid, 4 x 4*
A4364	Adhesive for ostomy or catheter*
A4365	Ostomy adhesive remover wipes*
A4366	Ostomy vent*
A4367	Ostomy belt*
A4368	Ostomy filter, any type *
A4369	Skin barrier liquid per oz*
A4371	Skin barrier powder per oz*
A4375	Drainable plastic pch w/ fcpl*
A4376	Drainable rubber pch w/ fcplt*
A4377	Drainable plstic pch w/o fp*
A4378	Drainable rubber pch w/o fp*
A4379	Urinary plastic pouch w/ fcpl*
A4380	Urinary rubber pouch w/ fcplt*
A4381	Urinary plastic pouch w/o fp*
A4382	Urinary hvy plstc pch w/o fp*
A4383	Urinary rubber pouch w/o fp*
A4384	Ostomy faceplt/silicone ring*

Bundled Supplies

Code	Brief Description
A4385	Ost skn barrier sld ext wear*
A4387	Ost clsd pouch w/ att st barr*
A4388	Drainable pch w/ ex wear barr*
A4389	Drainable pch w st wear barr*
A4390	Drainable pch ex wear convex*
A4391	Urinary pouch w/ ex wear barr*
A4392	Urinary pouch w/ st wear barr*
A4393	Urine pch w/ ex wear bar conv*
A4397	Irrigation supply, sleeve
A4398	Ostomy irrigation supply, bags*
A4399	Ostomy irrigation supply, cone/catheter*
A4400	Ostomy irrigation set*
A4402	Lubricant
A4404	Ostomy rings*
A4405	Nonpectin based ostomy paste*
A4406	Pectin based ostomy paste*
A4407	Ext wear ost skn barr <=4sq*
A4408	Ext wear ost skn barr >4sq*
A4409	Ost skn barr w flng <=4sq*
A4410	Ost skn barr w flng >4sq*
A4413	2 pc drainable ost pouch*
A4414	Ostomy sknbarr w flng <=4sq*
A4415	Ostomy sknbarr w flng >4sq*
A4416	Ost pch clsd w barrier/filtr*
A4417	Ost pch w bar/bltinconv/fltr*
A4418	Ost pch clsd w/o bar w filtr*
A4419	Ost pch for bar w flange/flt*
A4420	Ost pch clsd for bar w lk fl*

Bundled Supplies

Code	Brief Description
A4421	Ostomy supply, miscellaneous*
A4422	Ostomy pouch absorbent material*
A4423	Ost pch for bar w lk fl/fltr*
A4424	Ost pch drain w bar & filter*
A4425	Ost pch drain for barrier fl*
A4426	Ost pch drain 2 piece system*
A4427	Ost pch drain/barr lk flng/f*
A4428	Urine ost pouch w faucet/tap*
A4429	Urine ost pouch w bltinconv*
A4430	Ost urine pch w b/bltin conv*
A4431	Ost pch urine w barrier/tapv*
A4432	Os pch urine w bar/fange/tap*
A4433	Urine ost pch bar w lock fln*
A4434	Ost pch urine w lock flng/ft*
A4450	Non-waterproof tape*
A4452	Waterproof tape*
A4455	Adhesive remover or solvent
A4462	Abdominal dressing holder/binder**
A4465	Non-elastic binder for extremity
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4550	Surgical trays
A4556	Electrodes (e.g., apnea monitor)
A4557	Lead wires (e.g., apnea monitor)
A4558	Conductive paste or gel
A4647	Supply of paramagnetic contrast material, e.g., gadolinium
A4649	Surgical supply; miscellaneous

Bundled Supplies

Code	Brief Description
A4930	Sterile gloves per pair
A5051	Pouch, closed; with barrier*
A5052	Pouch, closed; without barrier*
A5053	Pouch, closed; use on faceplate*
A5054	Pouch, closed; use on barrier*
A5055	Stoma cap*
A5061	Pouch, drainable; with barrier*
A5062	Pouch, drainable; without barrier*
A5063	Pouch, drainable; use on barrier*
A5071	Pouch, urinary; with barrier*
A5072	Pouch, urinary; without barrier*
A5073	Pouch, urinary; use on barrier*
A5081	Continent device, plug*
A5082	Continent device, catheter*
A5093	Ostomy accessory, convex insert*
A5102	Bedside drainage bottle*
A5105	Urinary suspensory, with leg bag*
A5112	Urinary leg bag, latex*
A5113	Leg strap; latex*
A5114	Leg strap, foam or fabric*
A5119	Skin barrier; wipes, box per 50*
A5121	Skin barrier; solid, 6 x 6*
A5122	Skin barrier; solid, 8 x 8*
A5126	Adhesive, disc or foam pad*
A5131	Appliance cleaner*
A6010	Collagen based wound filler**
A6011	Collagen gel/paste wound fill**
A6021	Collagen dressing <=16 sq in**

Bundled Supplies

Code	Brief Description
A6022	Collagen drsg >6<=48 sq in**
A6023	Collagen dressing >48 sq in**
A6024	Collagen drsg wound filler**
A6025	Silicone gel sheet**
A6154	Wound pouch**
A6196	Alginate dressing, up to 16 sq. in.**
A6197	Alginate dressing, 16+ to 48 sq. in.**
A6198	Alginate dressing, 48+ sq. in.**
A6199	Alginate dressing, wound filler**
A6200	Composite dressing up to 16 sq. in. no bdr**
A6201	Composite dressing 16+ to 48 sq. in. no bdr**
A6202	Composite dressing 48+ sq. in. no bdr**
A6203	Composite dressing, up to 16 sq. in.**
A6204	Composite dressing, 16+ to 48 sq. in.**
A6205	Composite dressing, 48+ sq. in.**
A6206	Contact layer, up to 16 sq. in.**
A6207	Contact layer, 16+ to 48 sq. in.**
A6208	Contact layer, 48+ sq. in.**
A6209	Foam dressing, 16 sq. in. or less**
A6210	Foam dressing, 16+ to 48 sq. in.**
A6211	Foam dressing, 48+ sq. in.**
A6212	Foam dressing, up to 16 sq. in.**
A6213	Foam dressing, 16+ to 48 sq. in.**
A6214	Foam dressing, 48+ sq. in.**
A6215	Foam dressing, wound filler**
A6216	Gauze, non-impregnated, non-sterile**
A6217	Gauze, non-impregnated**
A6218	Gauze, non-impregnated**

Bundled Supplies

Code	Brief Description
A6219	Gauze, non-impregnated**
A6220	Gauze, non-impregnated**
A6221	Gauze, non-impregnated**
A6222	Gauze, impregnated, other than water or normal saline**
A6223	Gauze, impregnated, other than water or normal saline**
A6224	Gauze, impregnated, other than water or normal saline**
A6228	Gauze, impregnated, water or normal saline**
A6229	Gauze, impregnated, water or normal saline**
A6230	Gauze, impregnated, water or normal saline**
A6231	Hydrogel dsg <=16 sq in**
A6232	Hydrogel dsg >16<=48 sq in**
A6233	Hydrogel dressing >48 sq in**
A6234	Hydrocolloid dressing, wound cover**
A6235	Hydrocolloid dressing, wound cover**
A6236	Hydrocolloid dressing, wound cover**
A6237	Hydrocolloid dressing, wound cover**
A6238	Hydrocolloid dressing, wound cover**
A6239	Hydrocolloid dressing, wound cover**
A6240	Hydrocolloid dressing, wound filler, paste**
A6241	Hydrocolloid dressing, wound filler, dry form**
A6242	Hydrogel dressing, wound cover**
A6243	Hydrogel dressing, wound cover**
A6244	Hydrogel dressing, wound cover **
A6245	Hydrogel dressing, wound cover**
A6246	Hydrogel dressing, wound cover**
A6247	Hydrogel dressing, wound cover**
A6248	Hydrogel dressing, wound filler, gel**

Bundled Supplies

Code	Brief Description
A6250	Skin sealants, protectants, moisturizers, ointments**
A6251	Specialty absorptive dressing**
A6252	Specialty absorptive dressing**
A6253	Specialty absorptive dressing**
A6254	Specialty absorptive dressing**
A6255	Specialty absorptive dressing**
A6256	Specialty absorptive dressing, wound cover**
A6257	Transparent film, 16 sq. in. or less**
A6258	Transparent film, 16+ to 48 sq. in.**
A6259	Transparent film, 48+ sq. in.**
A6260	Wound cleansers any type/size**
A6261	Wound filler, gel/paste, not otherwise classified**
A6262	Wound filler, dry form, not otherwise classified**
A6266	Gauze, impregnated, other than water or normal saline**
A6402	Gauze, non-impregnated, sterile**
A6403	Gauze, non-impregnated, sterile**
A6404	Gauze, non-impregnated, sterile**
A6407	Packing strips, non-impreg**
A6410	Sterile eye pad**
A6411	Non-sterile eye pad**
A6412	Occlusive eye patch**
A6421	Pad bandage >=3<5" w/roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
A6422	Conf bandage ns >=3<5" w/roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
A6424	Conf bandage ns >=5" w/roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
A6426	Conf bandage s >=3<5" w/roll** (Deleted 2004 code not valid for dates of service after 3/31/04)

Bundled Supplies

Code	Brief Description
A6428	Conf bandage s >=5" w/roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
A6430	Lt compres bdg >=3<5"w /roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
A6432	Lt compres bdg >=5"w /roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
A6434	Mo compres bdg >=3<5"w /roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
A6436	Hi compres bdg >=3<5"w /roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
A6438	Self-adher bdg >=3<5"w /roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
A6440	Zinc paste bdg >=3<5"w /roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
A6441	Pad band w>=3" <5"/yd**
A6442	Conform band n/s w<3"/yd**
A6443	Conform band n/s w>=3"<5"/yd**
A6444	Conform band n/s w>=5"/yd**
A6445	Conform band s w <3"/yd**
A6446	Conform band s w>=3" <5"/yd**
A6447	Conform band s w >=5"/yd**
A6448	Lt compres band <3"/yd**
A6449	Lt compres band >=3" <5"/yd**
A6450	Lt compres band >=5"/yd**
A6451	Mod compres band w>=3"<5"/yd**
A6452	High compres band w>=3"<5"yd**
A6453	Self-adher band w <3"/yd**
A6454	Self-adher band w>=3" <5"/yd**
A6455	Self-adher band >=5"/yd**
A6456	Zinc paste band w >=3"<5"/yd**
A9900	Supply/accessory/service
A9901	Delivery/set up/dispensing

Bundled Supplies

Code	Brief Description
K0581	Ost pch clsd w barrier/filtr* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0582	Ost pch w bar/bltinconv/fltr* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0583	Ost pch clsd w/o bar w filtr* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0584	Ost pch for bar w flange/flt* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0585	Ost pch clsd for bar w lk fl* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0586	Ost pch for bar w lk fl/fltr* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0587	Ost pch drain w bar & filter* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0588	Ost pch drain for barrier fl* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0589	Ost pch drain 2 piece system* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0590	Ost pch drain/barr lk flng/f* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0591	Urine ost pouch w faucet/tap* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0592	Urine ost pouch w bltinconv* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0593	Ost urine pch w b/bltin conv* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0594	Ost pch urine w barrier/tapv* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0595	Os pch urine w bar/fange/tap* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0596	Urine ost pch bar w lock fln* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0597	Ost pch urine w lock flng/ft* (Deleted 2004 code not valid for dates of service after 3/31/04)
K0622	Confrm band non str <3in/rol** (Deleted 2004 code not valid for dates of service after 3/31/04)

Bundled Supplies

Code	Brief Description
K0623	Confrm band sterl>3in/roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
K0624	Lite compress wdth<3in/roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
K0625	Self adher wdth <3 in, roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
K0626	Self adher wdth >=5 in, roll** (Deleted 2004 code not valid for dates of service after 3/31/04)
L9900	Orthotic and prosthetic supply/accessory/ service
Q3031	Collagen skin test*
V2797	Vis item/svc in other code

Please note: CPT code 99070, which represents miscellaneous supplies provided by the physician, is not reimbursable by the UMP. Providers must bill specific HCPCS level II codes for supplies, prosthetics, and durable medical equipment.

7.4.3 Bundled Services

Under the UMP fee schedule RBRVS methodology, the following are considered "bundled" into the costs of other procedures and are not separately paid.

Bundled Services

Code	Brief Description
0003T	Cervicography
0021T	Fetal oximetry, trnsvag/cerv
0025T	Ultrasonic pachymetry (Deleted 2004 code not valid for dates of service after 3/31/04)
0031T	Speculoscopy
0032T	Speculoscopy w/direct sample
15850	Removal of sutures
20930	Spinal bone allograft
20936	Spinal bone autograft

Bundled Services

Code	Brief Description
22841	Insert spine fixation device
38204	B1 donor search management
43752	Nasal/orogastric w/stent
78890	Nuclear medicine data proc
78890-26	Nuclear medicine data proc
78890-TC	Nuclear medicine data proc
78891	Nuclear med data proc
78891-26	Nuclear med data proc
78891-TC	Nuclear med data proc
90473	Immunization oral/intranasal
90474	Immunization oral/intranasal
90885	Psy evaluation of records
90887	Consultation with family
90889	Preparation of report
91123	Irrigate fecal impaction
92531	Spontaneous nystagmus study
92532	Positional nystagmus study
92533	Caloric vestibular test
92534	Optokinetic nystagmus
92605	Eval for nonspeech device rx
92606	Non-speech device service
92613	Endoscopy swallow tst (fees)
92615	Eval laryngoscopy sense tst
92617	Interprt fees/laryngeal test
93740	Temperature gradient studies
93740-26	Temperature gradient studies
93740-TC	Temperature gradient studies
93770	Measure venous pressure
93770-26	Measure venous pressure

Bundled Services

Code	Brief Description
93770-TC	Measure venous pressure
94150	Vital capacity test
94150	Vital capacity test
94150-26	Vital capacity test
94150-TC	Vital capacity test
94760	Measure blood oxygen level[1]
94761	Measure blood oxygen level[1]
96545	Provide chemotherapy agent
97010	Hot or cold packs therapy
99000	Specimen handling
99001	Specimen handling
99002	Device handling
99024	Post-op follow-up visit
99025	Initial surgical evaluation (Deleted 2004 code not valid for dates of service of 3/31/04)
99056	Non-office medical services
99058	Office emergency care
99080	Special reports or forms[2]
99090	Computer data analysis
99091	Collect/review data from pt
99100	Special anesthesia service
99116	Anesthesia with hypothermia
99135	Special anesthesia procedure
99140	Emergency anesthesia
99141	Sedation, iv/im or inhalant
99142	Sedation, oral/rectal/nasal
99173	Visual screening test
99358	Prolonged serv, w/o contact
99359	Prolonged serv, w/o contact

Bundled Services

Code	Brief Description
99374	Home health care supervision
99377	Hospice care supervision
99379	Nursing fac care supervision
A0800	Amb trans 7 p.m. - 7 a.m.
G0102	Prostate cancer screening; digital rectal exam (DRE)
G0117	Glaucoma scrn hgh risk direc[3]
G0118	Glaucoma scrn hgh risk direc[3]
G0269	Occulsive device in vein art
R0076	Transportation of portable EKG

[1] Separate payment for CPT codes 94760 and 94761 may be allowed if supporting documentation is submitted that shows no other service was provided/billed on the same date of service.

[2] CPT code 99080, which represents completion of special reports such as insurance forms, is not reimbursable by the UMP. The patient is responsible for any charges for this service, as it is an excluded benefit.

[3] When no other payable service is reported, UMP will allow separate reimbursement for the glaucoma screening code (G0117 and G0118).

7.5 Maternity Services

Obstetric services provided and billed by a licensed physician, advanced registered nurse practitioner, certified nurse midwife, licensed midwife, hospital, or birthing center are covered under this benefit, provided plan coverage is in force at the time services are received. The provider must be able to provide the full scope of obstetric services (prenatal, delivery, and postnatal) in order for the UMP to provide coverage under this benefit, except in areas where there are provider access issues and prior authorization has been obtained. Prenatal diagnostic screening for congenital disorders is covered.

Nursery charges for the newborn infant(s) are also covered for the length of the mother's medically necessary childbirth-related hospital stay, provided the child is enrolled in accordance with PEBB provisions. Please refer to the "Obstetric and Newborn" section in the UMP *Certificate of Coverage* for more details on the benefit.

Charges for termination of pregnancy are covered. Charges for infertility services, in vitro fertilization, or artificial insemination are not covered.

Obstetrical services in a birthing center are subject to preauthorization requirements.

Please refer to the UMP *Certificate of Coverage* for details regarding the scope of coverage of these benefits.

7.6 Mental Health and Chemical Dependency Services

7.6.1 Mental Health (Counseling) Services

Covered services under this benefit include inpatient and outpatient hospital, and professional services for treatment of neuropsychiatric, mental, or personality disorders, including eating disorders (bulimia and anorexia nervosa). Services must be provided by a licensed physician, licensed psychologist, advanced registered nurse practitioner, licensed master of social work (LMSW), licensed mental health counselor (LMHC), licensed marriage and family therapist (LMFT), licensed community mental health agency, or state hospital. Services of LMSWs, LMHCs, and LMFTs are covered only for evaluation, assessment, and treatment of mental and emotional disorders and psychopathology (see Section 7.1.3.1 for more information on coverage and payment differentials for these provider types). Please refer to the UMP *Certificate of Coverage* for details regarding the scope of coverage of these benefits and approved provider types. Payment rules follow.

7.6.1.1 Payment Rules for Psychotherapy and Psychological Services

1. Psychotherapy and psychological services must be reported with the appropriate procedure code from the Psychiatry section of the CPT book.
2. Diagnostic psychological testing must be reported with the appropriate CPT code (e.g., 96100–96117).
3. The pharmacological management service codes (e.g., 90862 and M0064) may be billed only by those providers with prescriptive authority.
4. The pharmacological management service codes (e.g., 90862 and M0064) are not reimbursed separately with an evaluation and management service (e.g., 99201–99350) or psychotherapy service (e.g., 90804–90829).
5. The following CPT psychotherapy codes with "medical evaluation and management" included in the descriptor are not covered for licensed psychologists, LMSWs, LMHCs, or LMFTs: 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, and 90829.
6. More than one occurrence of a psychiatric diagnostic interview examination (e.g., 90801) per patient per year by the same provider is not reimbursed unless a different psychiatric condition arises.

7. A psychiatric diagnostic interview (e.g., 90801) is not reimbursed separately on the same day as an interactive psychiatric diagnostic interview (e.g., 90802).
8. An individual psychotherapy, insight-oriented, behavior-modifying and/or supportive service (e.g., 90804–90809, 90816–90822) is not reimbursed separately on the same day as an interactive individual psychotherapy service (e.g., 90810–90815, 90823–90829).
9. Individual psychotherapy may be covered on the same day as group therapy (e.g., 90846–90857).
10. No payment is made for group psychotherapy (e.g., 90853) on the same day as interactive group psychotherapy (e.g., 90857).
11. CPT codes 90885, 90887, and 90889 are bundled services. Therefore, separate reimbursement is not allowed for these codes.

7.6.2 Chemical Dependency Services

Chemical dependency is defined as repetitive use of alcohol or drugs to the extent that such use interferes with the user's social, psychological, or physical well-being. Chemical dependency does not include dependence on tobacco, caffeine, or food. Licensed substance abuse treatment facilities must be approved by the UMP. Please refer to the UMP *Certificate of Coverage* for details regarding the scope of coverage and benefit limit.

7.7 Other Medical Services

7.7.1 Drugs Incident to Physician Services

Separate payment is allowed if the covered drug is:

- Administered incidental to a provider's professional service; and
- Commonly administered in an office or clinic setting.

This policy applies to immunizations, therapeutic or diagnostic injections, and chemotherapy administration services covered by the plan. Please see the UMP *Certificate of Coverage* for plan benefits and scope of coverage details.

Special plan payment rules for these services, and for the drugs incident to these services, are described in the following sections.

The UMP generally follows Medicare's payment policy to determine the maximum allowances for covered drugs and biologicals administered by the professional provider. The *UMP Professional Provider Fee Schedule for Drugs and Biologicals* is available on the UMP Web site at **www.ump.hca.wa.gov**.

7.7.2 Immunizations

7.7.2.1 Service Coding and Reimbursement for Immunizations

Immunization administration CPT codes 90471 (and 90472, if appropriate) are payable in addition to the applicable immunization product codes 90476–90749. The number of units reported in the units field on the claim for code 90471 should not exceed one. If multiple immunizations are administered, the add-on CPT code 90472 may be reported in conjunction with CPT code 90471 for payment consideration.

If a significant separately identifiable evaluation and management service is performed, the appropriate E&M code may be reported in addition to the immunization administration codes 90471 and 90472 for payment consideration.

The maximum allowances for covered CPT immune globulin product codes and vaccine/toxoid product codes are included in the *UMP Professional Provider Fee Schedule for Drugs and Biologicals,* which is available on the UMP Web site at **www.ump.hca.wa.gov**.

For the following immune globulin product CPT codes, providers must indicate the appropriate number of units on the claim form based on the dosage indicated below for reimbursement purposes:

- Hepatitis B (CPT code 90371)–1 unit for each ml used

- Rabies immune globulin (CPT codes 90375–90376)– 1 unit for each 2 ml vial used

Please note: Immunizations for purposes of employment, travel, immigration, licensing, or insurance are not covered under the UMP. However, meningococcal vaccine is covered under the preventive care benefit for college students living in a dormitory environment.

7.7.3 Therapeutic or Diagnostic Injections (CPT Codes 90782–90788)

If a subcutaneous or intramuscular injection (90782) or an intramuscular antibiotic (90788) is provided on the same day as an evaluation and management service, the injections are bundled into the E&M service. However, if no E&M service is provided on the same day, separate payment is allowed for the injection.

Intra-arterial (90783) and intravenous therapeutic or diagnostic (90784) injections are separately reimbursed even when provided on the same day as an E&M service. Report the actual drug administered using the appropriate HCPCS level II "J" or "Q" code for separate payment consideration. However, these injections are not separately reimbursed if provided in conjunction with IV infusion therapy services (90780 and 90781).

If no other service is performed on the same day, intramuscular injection (90782) and intramuscular antibiotic (90788) can be billed in addition to a HCPCS level II "J" or "Q" code for payment consideration.

Providers are required to use the specific HCPCS level II "J" or "Q" code to report the drug administered. The name, manufacturer, strength, dosage, and quantity of the drug must be documented and retained in the patient's records, and be available for review upon request.

The UMP generally follows Medicare's payment policy to determine the maximum allowances for covered drugs and biologicals administered by the professional provider. The *UMP Professional Provider Fee Schedule for Drugs and Biologicals* is available on the UMP Web site at **www.ump.hca.wa.gov**.

When billing for the drugs and biologicals, providers must follow the descriptions of the HCPCS level II codes and include the correct number of units on the claim form for appropriate coverage consideration and reimbursement.

Unclassified or unspecified HCPCS level II drug codes should be billed only when there is not a specific code available for the drug being administered. In this situation, the name, manufacturer, strength, dosage, and quantity of the drug must be included with the unclassified or unspecified drug code for coverage and payment consideration. **Please note:** Codes J8499 and J8999 for oral drugs are generally not covered on UMP's fee schedule for professional providers.

7.7.4 Allergen Immunotherapy

1. When providing both the injection and antigen/antigen preparation, bill one CPT injection code (95115 or 95117) and one of the CPT antigen/antigen preparation codes (95145–95149, 95165, or 95170). The complete service CPT codes (95120, 95125, and 95130–95134) are not reimbursed by UMP.
2. CPT codes 95145–95149 and 95170 are antigen/antigen preparation codes for stinging/biting insects. All other antigen/antigen preparation services (e.g., for dust, pollens, etc.) are billed using either CPT code 95144 for single dose vials or CPT code 95165 for multiple dose vials.
3. CPT code 95144 should be used only when the allergist has prepared the extract to be injected by another physician.
4. Allergists who perform the complete service using treatment boards should bill one of the antigen/antigen preparation CPT codes (95145–95149, 95165, and 95170) and a CPT injection code (95115 or 95117).
5. Reimbursement for antigen/antigen preparation CPT codes (95145–95149, 95165, or 95170) is per dose. If a physician injects one dose of a multiple dose vial, bill for the total number of doses in the vial and an injection code. When that physician (or another physician)

injects the remaining doses at subsequent times, only the injection service should be billed.

6. Allergists billing both an injection and either CPT code 95144 or 95165 are reimbursed the injection plus the fee for CPT code 95165, regardless of whether CPT code 95144 or 95165 is billed.
7. An E&M visit may be billed in addition to the allergy immunotherapy code for payment consideration if other separately identifiable services are provided at the time. Supporting documentation for the E&M visit must be submitted to the UMP upon request.

7.7.5 Chemotherapy Administration (CPT Codes 96400–96549)

7.7.5.1 Coding and Reimbursement for Chemotherapy Administration

Chemotherapy administration services must be reported using the appropriate CPT code. Separate payment is made for chemotherapy administration regardless of whether the service occurs during an office visit in conjunction with infusion of another drug.

Infusion of saline, antiemetics, or any other nonchemotherapy drug under CPT codes 90780 and 90781 is not reimbursable when these drugs are administered at the same time as chemotherapy. When the infusion is done sequentially and not simultaneously with chemotherapy administration, the infusion procedure code(s) and the chemotherapy administration code will both be paid separately. In this coding situation, modifier 59 must be reported with the chemotherapy administration procedure code for the appropriate consideration and reimbursement.

7.7.5.2 Coding and Reimbursement for Chemotherapy Agents

Chemotherapy agents must be billed using the specific HCPCS level II "J" or "Q" codes. Office records must identify the name, manufacturer, strength, dosage, and quantity of the drug, and be available upon request. The *UMP Professional Provider Fee Schedule for Drugs and Biologicals* includes the allowed amounts for the chemotherapy agents, and is available on the UMP Web site at **www.ump.hca.wa.gov**.

7.7.6 Therapeutic Apheresis

Separate payment for established patient office or other outpatient visits (CPT codes 99211–99215), subsequent hospital care (CPT codes 99231–99233), and follow-up inpatient consultations (CPT codes 99261–99263), is not allowed on the same date that therapeutic apheresis (CPT codes 36511–36516) is provided.

Physicians furnishing therapeutic apheresis services may bill for the appropriate E&M visit or consultation code indicating the level of services provided in lieu of billing for the therapeutic apheresis services. The time spent in apheresis management may not be counted in determining the duration of time spent on critical care services (CPT codes 99291 and 99292).

The code for therapeutic apheresis includes payment for all medical management services provided to the patient on the same date of service. Therefore, payment is made for only one unit (of CPT codes 36511–36516) provided by the same physician, on the same date, for the same patient.

7.7.7 End Stage Renal Disease/Dialysis Services

CPT E&M codes 99231–99233 and 99261–99263 are not payable on the same service date as CPT hospital inpatient dialysis codes 90935, 90937, 90945, and 90947. Payment for the E&M services is bundled into the dialysis service.

Separate billing and payment for an initial hospital visit (CPT codes 99221–99223), an initial inpatient consultation (CPT codes 99251–99255), or a hospital discharge service (CPT code 99238), is allowed when billed on the same date as an inpatient dialysis service.

7.7.8 Ventilation Therapy

Separate reimbursement for ventilation management services (CPT codes 94656, 94657, 94660, and 94662) is not allowed when an E&M service is reported on the same day. Physicians may bill either the ventilation management codes or an E&M service.

7.7.9 RU-486 Abortion Drug and Related Professional Services

The RU-486 abortion drug, administered in the provider's office, is covered by the UMP. The drugs and related professional services must be submitted on the CMS-1500 claim form for payment consideration.

The maximum allowances for the drugs are determined by the UMP's payment policy for drugs administered in the provider's office. Use the following HCPCS codes to report the drugs on the claim form:

S0190 Mifepristone, oral, 200 mg.

S0191 Misoprostol, oral, 200 mcg.

Note: Professional services reported under HCPCS code S0199 will not be reimbursed by the UMP. Providers must bill the specific CPT codes for the professional services provided for reimbursement consideration by the UMP.

7.7.10 Miscellaneous Services

The plan provides benefits for the specialized medical services as listed below:

- Acupuncture
- Biofeedback therapy
- Blood and blood derivatives
- Bone, eye, and skin bank services
- Cardiac and pulmonary rehabilitation
- Diabetic education
- Treatment of eating disorders (bulimia, anorexia nervosa)
- PKU supplement for newborns
- Neurodevelopmental therapies
- Special nursing services
- Treatment of temporomandibular joint conditions

Please refer to the UMP *Certificate of Coverage* for details regarding scope of coverage of these benefits. For information on biofeedback therapy, refer to the UMP *Certificate of Coverage* under "Mental Health Treatment." Preauthorized biofeedback therapy for medical conditions may be covered under the medical benefit, as indicated in the UMP *Certificate of Coverage* under "Biofeedback Therapy."

7.8 Radiology Services

Covered services include x-rays and other imaging tests, studies, and examinations intended to establish a diagnosis or monitor the progress and outcome of therapy.

Diagnostic testing must be appropriate to the diagnosis or symptoms reported by the ordering physician and must be medically necessary. The ordering physician must belong to an approved provider type.

Mammograms are covered in accordance with a schedule established by the UMP and published in the UMP *Certificate of Coverage*.

Positron Emission Tomography (PET) scans are subject to UMP preauthorization requirements.

Please refer to the UMP *Certificate of Coverage* for details regarding the scope of coverage of these benefits.

7.8.1 Separate Payment for Radiologic Contrast Material

In general, the cost of radiologic contrast material is considered bundled into the payment for the associated radiology service. Separate payment for radiologic contrast material is not made except for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and intra-arterial injections when the patient has

one or more of the following characteristics (as documented in the patient's medical record):

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting;
- A history of asthma or allergy;
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;
- Generalized severe debilitation; or
- Sickle cell disease.

To bill for LOCM, use the appropriate HCPCS level II procedure codes A4644–A4646. The brand name and dosage of the LOCM must be documented in the patient's records.

UMP's fee schedule amounts for codes A4644, A4645, or A4646 are per milliliter (ml). These amounts are included in the *UMP Professional Provider Fee Schedule for Drugs and Biologicals*, which is available on the UMP Web site at **www.ump.hca.wa.gov**. The number of units reported in the units field on the claim form for these codes must be equal to the number of milliliters administered for appropriate reimbursement.

7.8.2 Radiopharmaceutical Diagnostic Imaging Agents

Separate payment is allowed for radiopharmaceutical diagnostic imaging agents used when performing nuclear medicine procedures.

The maximum allowed amounts for radiopharmaceutical agents are included in the *UMP Professional Provider Fee Schedule for Drugs and Biologicals*, which is available on the UMP Web site at **www.ump.hca.wa.gov**.

7.8.3 Transportation Reimbursement in Connection with Furnishing Diagnostic Tests

Payment of expenses associated with transportation of diagnostic equipment is generally included in the reimbursement for the service or procedure. Therefore, separate payment for transportation of diagnostic equipment is not allowed except for:

- Transportation of portable x-ray equipment billed under HCPCS level II codes R0070 (one patient) or R0075 (multiple patients) in connection with services furnished by portable x-ray suppliers.
- Services billed under CPT code 99082 (unusual travel), if a physician submits documentation to justify "very unusual travel."

Note: Portable x-ray services furnished in patients' homes are limited to the following tests:

1. Skeletal films involving extremities, pelvis, vertebral column, or skull;
2. Chest or abdominal films that do not involve the use of contrast media; and
3. Diagnostic mammograms.

7.8.4 Modifiers Required for Professional and Technical Components

The plan will reimburse for professional and technical components of radiology procedures according to Medicare payment rules. Providers must use the following modifiers, as appropriate, when billing radiology services.

26	**Professional Component** This modifier is used to bill for the professional component of a procedure which can be split into professional and technical components.
TC	**Technical Component** This modifier is used to bill for the technical component of a procedure which can be split into professional and technical components.

UMP recognizes that some providers may use modifiers -26 and/or -TC to separately report the professional and/or technical components of a service when the global service was provided. In these instances,

UMP's combined payment for the separate components will not exceed the fee schedule amount for the global procedure.

If another provider (for example, a facility) performs the technical component of a service, the provider performing only the professional component must report his/her service using the -26 modifier to signify that he/she performed only the professional component of the service.

The reverse is true in instances where another provider performs the professional component; in this case, the provider performing only the technical component must report the service using the -TC modifier to signify that only the technical component of the service was performed.

7.9 Laboratory Services

Covered services include diagnostic laboratory tests, studies, and examinations intended to establish a diagnosis or monitor the progress and outcome of therapy.

Diagnostic testing must be appropriate to the diagnosis or symptoms reported by the ordering physician and must be medically necessary. The ordering physician must be an approved provider. If the clinician refers lab tests to an outside vendor for processing, the diagnosis(es) must accompany the referral.

Please refer to the UMP *Certificate of Coverage* for details regarding scope of coverage of these benefits.

7.9.1 Payment for Laboratory Services

The following laboratory services are reimbursed based on the relative value units established in the Medicare *Physician Fee Schedule Data Base*:

- Clinical pathology consultations
- Bone marrow services
- Physician blood bank services
- Cytopathology services
- Surgical pathology services

UMP fee schedule amounts for laboratory services not identified above are based on the Medicare Clinical Laboratory Fee Schedule.

7.9.2 Modifiers Required for Professional and Technical Components

The plan will reimburse for professional and technical components of laboratory services according to Medicare payment rules. Providers must use the following modifiers, as appropriate, when billing laboratory services:

26	**Professional Component** This modifier is used to bill for the professional component of a procedure which can be split into professional and technical components.
TC	**Technical Component** This modifier is used to bill for the technical component of a procedure which can be split into professional and technical components.

UMP recognizes that some providers may use modifiers -26 and/or -TC to separately report the professional and/or technical components of a service when the global service was provided. In these instances, UMP's combined payment for the separate components will not exceed the fee schedule amount for the global procedure.

If another provider (for example, a facility) performs the technical component of a service, the provider performing the professional component must report his/her service using the -26 modifier to signify that he/she performed only the professional component of the service.

The reverse is true in instances where another provider performs the professional component; in this case, the provider performing the technical component must report the service using the -TC modifier to signify that only the technical component of the service was performed.

7.9.3
Stat Laboratory Services

Usual laboratory services are covered under the UMP fee schedule. In cases where laboratory tests are appropriately performed on a "stat" basis, the provider may bill the applicable HCPCS level II code (S3600 or S3601) for payment consideration. Reimbursement is limited to one stat charge per episode (not one per test). Tests ordered stat are limited to only those that are needed to manage the patient in a true emergency situation. The laboratory report must contain the name of the provider who ordered the stat test(s). The medical record must reflect the medical necessity and urgency of the service.

The stat charge will be paid only with the tests listed on the following two pages. Please refer to a CPT book for complete code descriptions.

> The UMP *Billing & Administrative Manual* contains abbreviated definitions of procedure codes. For billing purposes, please refer to the most current edition of the CPT and HCPCS books for complete descriptions of the procedure codes.

Stat Laboratory Tests

Code	Brief Description
80048	Basic metabolic panel
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen
80101	Drug screen
80156	Assay of carbamazepine
80162	Assay of digoxin
80164	Assay, dipropylacetic acid
80170	Assay of gentamicin
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin, total
80188	Assay of primidone
80192	Assay of procainamide
80194	Assay of quinidine
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis, nonauto w/ scope
81001	Urinalysis, auto w/ scope
81002	Urinalysis nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urinalysis
82003	Assay of acetaminophen
82009	Test for acetone/ketones
82040	Assay of serum albumin
82055	Assay of ethanol
82150	Assay of amylase
82247	Bilirubin, total
82248	Bilirubin, direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82550	Assay of ck (cpk)
82565	Assay of creatinine

Code	Brief Description
82803	Blood gases: pH, pO_2 & pCO_2
82945	Glucose other fluid
82947	Assay quantitative, glucose
83615	Lactate (LD) (LDH) enzyme
83663	Fluoro polarize, fetal lung
83664	Lamellar bdy, fetal lung
83735	Assay of magnesium
83874	Assay of myoglobin
83880	Natriutetic peptide
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
84157	Assay of protein, other
84295	Assay of serum sodium
84302	Assay of sweat sodium
84450	Transferase (AST) (SGOT)
84484	Assay of troponin, quant
84512	Assay of troponin, qual
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
84702	Chorionic gonadotropin test
85004	Automated diff wbc count
85007	Differential WBC count
85025	Automated hemogram
85027	Automated hemogram
85032	Manual cell count, each
85046	Reticyte/hgb concentrate
85049	Automated platelet count
85378	Fibrin degradation
85380	Fibrin degradation, vte
85384	Fibrinogen
85396	Clotting assay, whole blood
85610	Prothrombin time
85730	Thromboplastin time, partial
86308	Heterophile antibodies
86403	Particle agglutination test
86849	Immunology procedure
86880	Coombs test
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86920	Compatibility test
86921	Compatibility test
86922	Compatibility test
86971	RBC pretreatment
87205	Smear, stain & interpret
87210	Smear, stain & interpret
87281	Pneumocystis carinii, ag, if
87327	Cryptococcus neoform ag, eia
87400	Influenza a/b, ag, eia
88400	Bilirubin total transcut
89051	Body fluid cell count
G0306	CBC/diffwbc w/o platelets
G0307	CBC without platelet

7.10 Anesthesia Services

Services covered under this benefit include anesthesia services related to medically necessary surgery or pain management for a covered condition. Please refer to the UMP *Certificate of Coverage* for details regarding scope of coverage of these benefits.

7.10.1 Anesthesia Payment System Overview

The Anesthesia Payment System was developed and adopted by the following three Washington State agencies:

- **The Health Care Authority (HCA)**–The state agency that administers the Uniform Medical Plan (UMP) for public employees and retirees.
- **The Department of Labor and Industries (L&I)**–The state agency that administers the state's workers' compensation program (State Fund Industrial Program only).
- **The Medical Assistance Administration (MAA), within the Department of Social and Health Services (DSHS)**–The state agency that administers the state's Medicaid program.

The Reimbursement Steering Committee (RSC), consisting of members from the three state agencies, develops, maintains, and updates the anesthesia fee schedules and approves payment policies. The State Agency Anesthesia Technical Advisory Group (ATAG), which represents anesthesiologists, certified registered nurse anesthetists (CRNAs), and billing professionals, advises the RSC on anesthesia payment policies and reimbursement.

Anesthesia services are reimbursed according to actual time units and anesthesia base units. For the majority of the CPT anesthesia codes, the anesthesia bases in the UMP payment system are the same as the anesthesia base units adopted by both the Centers for Medicare & Medicaid (CMS) and the American Society of Anesthesiologists (ASA). For the CPT anesthesia codes where CMS and the ASA bases are different, CMS's anesthesia bases are used, with a few exceptions. Payment for some procedures, including pain management services, intubation, Swan-Ganz insertion and placement, and selected surgical services, is based on the UMP *Professional Provider Fee Schedule* maximum allowances.

7.10.2 Anesthesia Procedure Codes

Anesthesia services paid according to base and time units must be billed with CPT anesthesia codes 00100 through 01999 with the applicable anesthesia modifier. Refer to Section 7.10.3 for the appropriate modifiers. The anesthesia procedure codes should be selected according to the descriptions published in CPT.

7.10.3 Anesthesia Modifiers

Providers must report the applicable anesthesia modifier from the table below with the appropriate anesthesia procedure code for payment consideration. The UMP accepts all valid CPT/HCPCS modifiers; however, the modifiers identified in the table are the only ones that affect payment for the anesthesia services.

Physician Performing

AA	Anesthesia service performed personally by anesthesiologist

Physician Directing

QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QY	Medical direction of one CRNA by an anesthesiologist

Physician Supervising

AD	Medical supervision by a physician

CRNA Performing

QX	CRNA service with medical direction by a physician
QZ	CRNA service without medical direction by a physician

Please note: Special instructions for the above-referenced modifiers:

1. **Medical direction of anesthesia modifiers (QK and QY)**.

   The UMP follows Medicare's payment policy for medical direction of anesthesia services.

For each patient, the physician is required to:

- Perform a pre-anesthetic examination and evaluation;
- Prescribe the anesthesia plan;
- Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;
- Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions;
- Monitor the course of anesthesia administration at frequent intervals;
- Remain physically present and available for immediate diagnosis and treatment of emergencies; and
- Provide indicated post-anesthesia care.

In addition, the physician may direct no more than four anesthesia services concurrently and may not perform any other services while directing the single or concurrent services. The physician may attend to medical emergencies and perform other limited services (as Medicare allows) and still be deemed to have medically directed anesthesia procedures. The physician is required to document in the patient's medical record that the medical direction requirements identified above were met.

2. **Monitored anesthesia care service**. Monitored anesthesia care is reimbursed in the same way as regular anesthesia care, but instead of using the QS modifier, services should be billed in the following manner:
   - If the physician personally performs the services, bill modifier AA.
   - If the physician directs four or fewer concurrent procedures and monitored care represents two or more of the procedures, bill modifier QK.
   - If the CRNA personally performs all of the service, bill modifier QZ.
   - If the CRNA is medically directed, bill modifier QX.

7.10.4 Anesthesia Time Units

The anesthesia payment system is based on a per-minute reporting system. Providers must report the actual anesthesia minutes rounded to the next whole minute in the units field (24G) on the CMS-1500 claim form. The UMP will apply the specific base units for the particular procedure code being billed.

Anesthesia time begins when the provider starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision).

Following Medicare's payment policy, providers may sum up blocks of time around a break in continuous anesthesia care, as long as there is continuous monitoring of the patient within the blocks of time. This policy does not alter the fundamental principle that anesthesia time represents a continuous block of time when a patient is under the care of an anesthesiologist or CRNA. Billing of time units for the pre-anesthesia exam and evaluation is not allowed as these services are included in the base unit component.

7.10.5 Add-on Anesthesia Procedure Codes

7.10.5.1 Burn Excisions or Debridement

Providers may report the CPT anesthesia add-on code 01953 in addition to the primary anesthesia code 01952 when it is appropriate for payment consideration. In such a situation involving anesthesia for second- and third-degree burn excision or debridement, the **total** anesthesia minutes are reported in the units field (24G) with the primary anesthesia code 01952. The units field (24G) on the claim form for the add-on code 01953 must represent one unit for each additional 9% total body surface area or part thereof. (Refer to the CPT book for the complete descriptions of procedure codes.)

7.10.5.2 Obstetric

The CPT anesthesia add-on codes 01968 (Cesarean delivery following neuraxial labor analgesia/anesthesia) and 01969 (Cesarean hysterectomy following neuraxial labor

analgesia/anesthesia) may be reported in conjunction with CPT anesthesia code 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery) when it is appropriate for payment consideration. In these obstetric situations, the anesthesia time for the primary and add-on procedures are reported and paid separately.

7.10.6 Anesthesia Maximum Allowance

The UMP maximum allowance for payment of anesthesia services is determined as follows:

Step	Maximum Allowance Calculation
1	Multiply anesthesia base units by 15
2	Add total billed minutes to value from step 1
3	Multiply total from step 2 by UMP's per-minute conversion factor*

* In UMP's claims system, the 15-minute conversion factor is translated into an equivalent per minute conversion factor (for example, a conversion factor of $43.42 converts to $2.8947/minute)

Sample calculation

Billed time from provider = 120 minutes

UMP anesthesia base units = 5 units

UMP maximum allowance = (base x 15 + billed time) x per minute conversion factor

= (5 x 15 + 120) x $2.8947

= $564.47

Note: If an anesthesiologist or CRNA personally performs the anesthesia service, UMP reimbursement is based on 100 percent of the maximum allowable amount. In a team care situation, where an anesthesiologist medically supervises or medically directs the CRNA services, reimbursement to the anesthesiologist and CRNA is based on 50 percent of the total maximum allowance.

7.10.7 Anesthesia Payment Limitations for Obstetric Deliveries

A maximum time of six hours (360 minutes) per obstetric delivery is allowed for epidural anesthesia.

7.10.8 Pain Management and Other Services Paid Under the RBRVS Methodology

Some procedures commonly performed by anesthesiologists and CRNAs are reimbursed using the RBRVS maximum allowance, instead of anesthesia base and time units. These services include most pain management services, intubation, Swan-Ganz insertion and placement, as well as other selected surgical services. Providers should bill the applicable CPT surgery or medicine codes (with no anesthesia modifier) for reimbursement consideration. Refer to the UMP *Anesthesia Fee Schedule* for the RBRVS maximum allowances for these services.

7.10.9 Anesthesia Services Performed by the Surgeon (CPT modifier -47) Payment Policy

Separate reimbursement for local, regional, digital block, or general anesthesia administered by the surgeon is not allowed by the UMP. Based on Medicare's policy, these services are not separately payable, as they are considered in the RBRVS maximum allowance for the procedure.

7.10.10 Acupuncture Services

Acupuncture performed by a physician for anesthesia or pain management should be reported with the applicable CPT acupuncture treatment codes for payment consideration.

See the UMP *Certificate of Coverage* for scope of coverage information and benefit limits.

7.11 Therapy Services

7.11.1 Physical, Occupational, Speech, and Massage Therapy Services

Please refer to the UMP *Certificate of Coverage* for details regarding scope of coverage and benefit limits.

7.11.1.1 Billing and Payment Rules for Physical Therapy Services

1. **Physical therapy initial evaluation**: CPT code 97001 is to be used to report the initial evaluation before the plan of care is established. This evaluation is for the purpose of evaluating the patient's condition and establishing the plan of care.
2. **Physical therapy periodic re-evaluation**: CPT code 97002 is to be used for reporting the re-evaluation of a patient who has been under an established plan of care. This evaluation is for the purpose of evaluating the patient's condition and revising the patient's plan of care.
3. Physical therapists must bill the appropriate CPT physical medicine and rehabilitation codes (97010–97750 and 97799) for specific modalities and procedures.
4. CPT evaluation and management codes (99201–99350) are not payable when billed by a physical therapist.

7.11.1.2 Billing and Payment Rules for Occupational Therapy

1. **Occupational therapy initial evaluations**: CPT code 97003 is to be used to report the initial occupational therapy evaluation before the plan of care is established by the occupational therapist (OT) or physician. This evaluation is for the purpose of evaluating the patient's condition and establishing the plan of care.
2. **Occupational therapy re-evaluation**: CPT code 97004 is to be used to report the re-evaluation of a patient who has been under a plan of care established by an OT or a physician. This evaluation is for the purpose of evaluating the patient's condition and revising the plan of care under which the patient is being treated.
3. Occupational therapists must bill the appropriate codes within the physical medicine and rehabilitation section of CPT.
4. CPT evaluation and management codes 99201–99350 are not payable when billed by an occupational therapist.

7.11.1.3 Billing and Payment Rules for Speech Therapy Services

1. Speech therapy services should be reported with the applicable CPT codes.
2. Please note that only one unit should be reported with CPT codes 92506–92508 per day, regardless of the duration of the time for the visit. If multiple units are reported, payment will be capped at 1 unit.

7.12 Osteopathic Services

7.12.1 Payment Rules for Osteopathic Manipulation Therapy (OMT), (CPT Codes 98925–98929)

- The UMP reimburses an evaluation and management (E&M) procedure code in addition to an OMT procedure code only if the patient's condition requires a

significant, separately identifiable E&M service above and beyond the usual pre- and post-service work associated with the procedure. The physician must bill the E&M procedure code with a modifier -25 and the level of E&M service billed must be supported by documentation in the patient's record. The supporting documentation must be provided to the UMP upon request.

- Manipulations of the spine or extremities, or office calls in which such manipulations are performed (which includes codes 98925–98929), are limited to a combined total of 10 per calendar year. See Section 7.13.3 for the UMP payment policy on complementary and preparatory services.

7.13 Chiropractic Services

Manipulations of the spine or extremities, or office visits in which such manipulations are performed, are limited to a combined total of 10 visits per calendar year. Please refer to the UMP *Certificate of Coverage* for details regarding scope of coverage of these benefits.

7.13.1 Chiropractor Manipulation Treatment (CPT Codes 98940–98943)

The CPT codes and definitions must be followed when billing the UMP for manipulations of the spine or extremities. Depending on the number of spinal regions treated, report CPT code 98940, 98941, or 98942 as indicated in the CPT book. When manipulation of the extremities is performed, CPT code 98943 may be separately reported for payment consideration.

Note: UMP does not recognize multiple units on the claim form for any of the chiropractic manipulation codes.

Multiple procedure rules apply when manipulations of the spine and extremities are reported on the same date of service. The maximum allowance for the extremity manipulation code will be reduced to 50 percent in this circumstance. In billing multiple procedures, modifier –51 must be reported with the extremity manipulation code on the claim form.

The chiropractic manipulative treatment codes 98940–98943 include a premanipulation patient assessment.

7.13.2 Payment Rules for Separate Reporting of Evaluation and Management Services and Other Chiropractic Services

UMP follows the CPT book definitions for E&M services for new and established patients. If a provider has treated a patient for any reason within the last three years, the person is considered an established patient. (See CPT book for complete code descriptions, definitions, and guidelines.)

Chiropractic physicians may report the first four levels of CPT new patient office visits codes 99201–99204 and the first four levels of CPT established patient office visit codes 99211–99214 when appropriate for UMP payment consideration.

7.13.2.1 New Patient E&M Services (99201–99204)

A new patient E&M office visit code is payable only once within a three-year period, regardless of whether the services are billed with modifier -22. New patient E&M office visit codes are payable with manipulation codes only when all of the following conditions are met:

- The E&M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included in the manipulation visit;

- Modifier -25 is added to the new patient E&M code; and
- Supporting documentation describing the service(s) provided is available in the patient's record.

7.13.2.2 Established Patient E&M Services (99211–99214)

An established patient E&M office visit code is not payable on the same day as a new patient E&M office visit code regardless of whether the services are billed with modifier -22. Established patient E&M codes are not payable in addition to manipulation codes for follow-up visits except when all of the following conditions are met:

- The E&M service is for the **initial visit** for a **new condition** or **new injury**;
- The E&M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included in the manipulation visit;
- Modifier -25 is added to the E&M code; and
- Supporting documentation describing the service(s) provided is available in the patient's record.

When a patient requires re-evaluation for an existing condition or injury, either an established patient E&M CPT code (99211–99214) or a chiropractic manipulation code (98940–98943) is payable. Payment will not be made for both. Modifier -25 is not applicable in this situation.

Supporting documentation for separate reporting of evaluation and management services must be provided to the UMP upon request.

7.13.3 Complementary and Preparatory Services

Patient education or complementary and preparatory services are not separately reimbursed. Complementary and preparatory services are defined by the UMP as interventions that are used to prepare a body region for or facilitate a response to a spinal or extremity manipulation/adjustment. For example, the application of heat or cold and pre-manipulation exercise programs are considered complementary and preparatory services that are not separately payable.

7.14 Podiatry Services

Routine foot care procedures, corrective shoes, treatment of fallen arches or symptomatic complaints of the feet, orthotics, and prescriptions thereof, and routine hygienic care of the feet are not covered by the UMP. The UMP covers foot care appliances for prevention of complications associated with diabetes. Other services rendered by a podiatric physician are covered in accordance with the plan benefits. Please refer to the UMP *Certificate of Coverage* for details regarding scope of coverage of these benefits.

7.15 Vision Services

Coverage and payment limitations for routine eye examinations and the purchase of lenses, frames, and contact lenses, and payment for implant lenses in connection with cataract surgery or surgery for a missing portion of the eye, are described in the UMP *Certificate of Coverage*.

Please note: The limitations for vision hardware listed in the *Certificate of Coverage* are benefit limitations, not fee schedule limitations. Providers may bill the enrollee for the difference between the benefit limitation for vision hardware and the provider's billed charges.

7.16 Dental Services

Routine and preventive dental services, orthognathic surgery, dental implants, and nonsurgical treatment of TMJ are not covered under the plan, but may be covered under a PEBB dental plan. Under the UMP, services of dentists are covered only for specific surgical treatments and treatment of certain injuries. Please refer to the UMP *Certificate of Coverage* for details regarding scope of coverage of these benefits.

7.17

Prescription Drugs

The UMP offers a prescription drug benefit through both a retail and a mail-order pharmacy benefit manager (PBM). Both are administered by Express Scripts, Inc. Most pharmacies in Washington State are preferred with the UMP network. General questions related to mail-order or retail prescriptions can be answered by calling Express Scripts at 1-866-576-3862. Providers may call in prescriptions to 1-800-763-5502, or fax to 1-800-396-2171. Faxing on provider letterhead will expedite processing.

For drugs requiring coverage review or preauthorization, please call Express Scripts at 1-800-417-8164. Be prepared to provide the patient's UMP I.D. number and some brief clinical information that would show the medical necessity for these drugs. If you prefer to fax preauthorization requests to Express Scripts, the request with the pertinent information should be faxed to 1-877-697-7192.

UMP network pharmacies offer a discounted rate to UMP enrollees. Enrollee out-of-pocket expenses are much less if generic drugs are purchased. Network pharmacies will handle all claims submission for the enrollee, and once the annual prescription drug deductible has been met, the enrollee is responsible only for the applicable coinsurance at the network pharmacy point of sale.

The UMP offers a three-tier prescription drug benefit design. UMP enrollees will save money when prescriptions are dispensed according to the UMP Preferred Drug List (PDL). Enrollees have received an abbreviated version of the PDL that indicates the cost-share tier for the most commonly prescribed medications.

Specific information on the UMP's PDL and Drug Utilization Program is available on the UMP Web site at **www.ump.hca.wa.gov** or by contacting Express Scripts at 1-866-576-3862.

Please note: UMP will start to phase-in a new state PDL during 2004 as a result of recent state legislation. The legislation established a Pharmacy and Therapeutics (P&T) Committee, staffed by Washington licensed health care professionals, to develop a preferred drug list based on clinical evidence and criteria for safe, effective, and appropriate prescribing.

For 2004, the UMP's PDL will include drugs from the state's PDL (for drugs already reviewed through the state process) and drugs from an Express Scripts National formulary (for drug classes not yet reviewed). The P&T Committee meets quarterly to review additional drug classes. Once the reviews are completed, the UMP PDL may change based on the recommendations of the P&T Committee.

Under the new legislation, state-operated prescription drug programs (such as UMP) are required to develop a process that allows physicians and other prescribers to endorse the state PDL, and requires pharmacists to automatically substitute the preferred drug for nonpreferred drugs prescribed. Endorsing providers will still have he option of indicating "dispense as written" (DAW) on a prescription for a nonpreferred drug when they feel it is more appropriate for the patient's medical needs. Patients may also ask the pharmacist to dispense the nonpreferred drug. Regardless of whether the prescriber has indicated DAW on the prescription, enrollees pay a higher cost-share when they receive a nonpreferred drug.

Please refer to the UMP *Certificate of Coverage*, "Prescription Drugs" section, for benefit exclusions and a description of drugs that are covered under the plan.

7.18

Tobacco Cessation Services

The UMP covers services to assist enrollees in withdrawing from tobacco dependence through the *Free & Clear* tobacco cessation program. This is the only tobacco cessation program covered by UMP. Please refer to the UMP *Certificate of Coverage* for details regarding scope of coverage of these benefits. For information regarding the *Free & Clear* tobacco cessation program, call 1-800-292-2336.

Section 8

Provider Inquiries, Complaints, Reconsideration Procedures, and Dispute Resolutions

Please note: *The section below applies specifically to provider concerns. There is a separate appeals process for enrollees seeking a change in UMP coverage or benefit determinations. Complaints and appeals on behalf of enrollees should be addressed under that process, which is described in detail in the UMP* Certificate of Coverage.

Questions? Call 425-670-3046 or 1-800-464-0967.

8.1

Provider Inquiry, Complaint, Reconsideration Procedures, and Dispute Resolutions

The UMP has specific procedures for provider inquiries, complaints, and claim reconsideration requests. Definitions for each of these and the procedures follow.

8.1.1 Inquiry

A request for information or for an explanation.

If you have an inquiry such as a question on claims payment status, plan benefits, or enrollee eligibility, please call UMP Provider Services at 425-670-3046 or 1-800-464-0967. In most cases, your question will be answered right away.

8.1.2 Complaint

An expression of dissatisfaction submitted on behalf of a provider regarding:

- Coverage or payment for health care services; or
- UMP policies or practices.

To register a complaint, you may also contact UMP Provider Services at the above numbers; fax the complaint to 425-670-3197; or write to:

Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34578
Seattle, WA 98124-1578

Most complaints will be resolved immediately or within 24 hours of receipt. However, for more complex issues, the turnaround time for reviewing and responding to provider complaints may be up to 30 calendar days.

8.1.3 Reconsideration

Reevaluation of a previous decision by UMP in response to a provider's written request. The request may be in reference to:

- An adverse decision regarding a complaint;
- An unresolved claims processing issue;
- Decision to deny, modify, reduce, or terminate payment, coverage, or preauthorization for health care services or benefits. (Note that issues raised specifically on behalf of an enrollee or at the direction of an enrollee follow a separate appeals process described in the UMP *Certificate of Coverage*, and are not considered provider reconsiderations.)

There are two levels of **Provider Reconsiderations:**

Level 1: Within 180 days of receiving the notice of action leading to the request, submit your request for reconsideration to:

Uniform Medical Plan
(or UMP Neighborhood)
First-Level Provider Reconsideration
P.O. Box 34578
Seattle, WA 98124-1578

Please include the date of service and indicate clearly the issues that you wish to be reconsidered. Your request will be assigned to the appropriate experienced UMP staff, depending upon the issue.

Most requests are completed within 30 calendar days of the date the UMP received your request for reconsideration. If the decision is to reprocess the claim, you will receive a Detail of Remittance as notification. Otherwise, you will receive a written response.

Level 2: If you do not agree with the decision at Level 1 of the reconsideration process, you may submit a request for further reconsideration to:

Uniform Medical Plan
(or UMP Neighborhood)
Provider Relations Committee
Second-Level Provider Reconsideration
P.O. Box 34578
Seattle, WA 98124-1578

Requests for Level 2 reviews must be submitted within 60 calendar days of the date of the Level 1 determination. Include all of the information that was reviewed through the Level 1 reconsideration process, a copy of the Level 1 determination and any other information or documentation you think may be helpful. Your request for Level 2 reconsideration will be reviewed by our Provider Relations Committee. Most decisions will be made within 30 calendar days from receipt of your request for reconsideration.

Please note: There are no further reconsideration processes available through the UMP for non-network providers. The level 2 reconsideration process is the final decision of the UMP. If you are a network provider and are not satisfied with the outcome of the second level determination, you may request a dispute hearing with the Administrator of the Health Care Authority (HCA), using the dispute resolution procedure described below.

8.1.4 Dispute Resolution

A network provider may request a dispute hearing with the Administrator of the HCA. This procedure is not offered to non-network providers. Also, it does not apply to issues raised on behalf of enrollees (see the current UMP *Certificate of Coverage* for enrollee appeals procedures). Disputes will be resolved as quickly as possible.

A. The request for a dispute hearing must:
   - Be in writing and signed by the provider requesting the hearing or the provider's representative;
   - State the disputed issue(s);
   - Identify the pertinent contract provision(s);
   - State the provider's position on the issues;
   - Confirm that all other contractually available procedures for resolving the issue have been exhausted;
   - Include the name and address of the provider, as well as the name of any person acting for provider in the matter of the hearing; and
   - Be mailed within 30 days of the date of the letter with the second level decision to:

     Uniform Medical Plan
     (or UMP Neighborhood)
     Provider Dispute Hearing Request
     P.O. Box 91118
     Seattle, WA 98111-9218

B. The UMP Director of Operations may provide a written statement setting forth UMP's position and reasoning, and including any information that may be helpful. Any statement by UMP on the dispute must be mailed to the Administrator and the provider within 20 working days after receipt of the provider's statement.

C. The Administrator shall review the written statements and reply in writing to the provider and UMP Director of Operations within 30 working days. The Administrator may extend this period by notifying all parties.

D. The Administrator may designate someone to act on his or her behalf, following the same procedures and with the same effect as described above.

Both parties to the dispute will continue without delay to carry out all their respective responsibilities as defined by contract which are not affected by the dispute. Both parties will act in good faith in the dispute resolution and in all matters. Both parties will settle disputes without using this process whenever possible.

8.2

Provider Contract or Network Issues

Inquiries, complaints, or disputes concerning the following issues should be directed to the UMP Provider Services Manager: provider contract provisions, credentialing criteria for network participation, and approved provider types. Correspondence regarding these issues may be sent to:

Uniform Medical Plan
(or UMP Neighborhood)
Provider Services Manager
P.O. Box 91118
Seattle, WA 98111-9218

Appendix A-2 UMP PPO Explanation of Benefits (EOB) Example

UNIFORM MEDICAL PLAN
PO BOX 34850
SEATTLE WA 98124-1850

A BENEFIT PROGRAM FOR EMPLOYEES AND RETIREES OF WASHINGTON STATE

Important: Keep this for your permanent records and tax purposes

For questions or review of the decision, please write:

UNIFORM MEDICAL PLAN
P O BOX 34850
SEATTLE WA 98124-1850

For questions or review of the decision, please phone:

425-670-3000
1-888-380-2822 Toll Free

TEST
19401 40th AVE. W Ste 200
Lynnwood, WA 98036

Employee: TEST
Patient: TEST
Relationship: EMPLOYEE
Member ID: 999999999
Patient Acct No: 01
Provider No: 999999999
Claim No: TEST CLAIM-00
Date: 04/10/2004

EXPLANATION OF BENEFITS

Provider/Date(s) of Service	Proc. Code	Billed Charge	Non Covered Amount	Message Code	PPO Savings	Allowed Amount	Applied to Deductible	Balance	Pct %	Total
PHYSICIAN MD 03/00/04 - 03/20/04	99213	75.00		PPU	9.68	65.32		65.32	90	58.79
PHYSI1CIAN MD 03/20/04 - 03/20/04	72040	60.00		PPU	16.93	43.07		43.07	90	38.76
TOTALS		135.00			26.61	108.39	0.00	108.39		97.55
									Less Adjustments:	0.00
									Total:	97.55

Employee Responsibility **10.84** **Other Insurance Paid** **0.00**

Messages

THANK YOU FOR USING A UNIFORM MEDICAL PLAN
PARTICIPATING PROVIDER
PPU THIS IS YOUR PLAN'S NETWORK CONTRACTUAL ALLOWANCE FOR THIS SERVICE.
PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.

Accumulators

YOU HAVE MET 200.00 OF YOUR 200.00 DEDUCTIBLE FOR 01/01/2004 - 12/31/2004

UNIFORM MEDICAL PLAN
P O BOX 34850
SEATTLE WA 98124-1850
Toll Free: 1-888-380-2822

DOCTORS CLINIC
PO BOX 999
SEATTLE WA 98124

PHYSCIAN MD

SEE LAST PAGE FOR
EXPLANATION OF CODE

PROV#: 999999999900
TAX#: 9999999999
DATE: 04/02/2004
Draft #: 0000000
ENVOY/NEIC ID#: 000000000

PATIENT NAME ACCOUNT #	BENEFIT ID # CLAIM #	APC	SVC DATE	REV/PROC CODE	#	BILL AMOUNT	ALLOWED AMOUNT	NONCOV'D	CODE	DEDUCTIBLE AMOUNT	COPAY COINS	PPO DISCOUNT	PATIENT BALANCE	AMOUNT PAID
TEST	999999999													
C999999	TEST CLAIM-00													
			03/20/04	99213	1	75.00	65.32	.00	PPU	.00	6.53	9.63	6.53	58.79
			03/20/04	72040	1	60.00	43.07	.00	PPU	.00	4.31	16.93	4.31	38.76
	APDRG			CLAIM TOTAL		135.00	108.39	.00		.00	10.84	26.56	10.84	
													PAYMENT	97.55

TOTAL PAID 97.56

Code Descriptions

****
PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE LISTING TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT PAYMENT AMOUNT.
****
PPU THIS IS YOUR PLANS PARTICIPATING PROVIDERS CONTRACTUAL ALLOWANCE FOR THIS SERVICE. PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.
*** REQUESTS FOR RECONSIDERATION OF THE WAY A CLAIM WAS PROCESSED, TO INCLUDE BUNDLING, COB OR ALLOWABLE FEE ISSUES, SHOULD BE DIRECTED TO:
UNIFORM MEDICAL PLAN, P.O. BOX 34578, SEATTLE, WA 98125-1578

UMP Neighborhood
Administered by the Uniform Medical Plan

Appendix A-5

This supplement provides information and instructions for the UMP Neighborhood Care Systems and other providers outside of the Care Systems who may also treat UMP Neighborhood enrollees. **Billing and claims submittal procedures for services to UMP Neighborhood enrollees are the same whether or not the provider is affiliated with the enrollee's Care System.** However, higher enrollee cost-sharing applies for most services outside their Care System, with some exceptions.

Section 1

Quick Reference Notes

1.1

How to Reach Us

Uniform Medical Plan Web site:

www.ump.hca.wa.gov

1.1.1 Addresses and Phone Numbers

UMP Neighborhood Customer and Provider Services

- Benefits information
- Claims status and information
- Enrollee eligibility information*
- General billing questions

Automated Enrollee Eligibility Information:
Toll-free: 1-800-335-1062
(Have subscriber I.D. number available, and select #2 for "PEBB subscriber information.")

- Interactive Voice Response (IVR) system
- Medical review
- Prenotification/preauthorization
- Referral process
- Verify provider's Care System or network status

UMP Neighborhood
P.O. Box 34850
Seattle, WA 98124-1850

Toll-free: 1-888-380-2822
Local: 425-670-3018
Fax: 425-670-3199

Case Management Services:
Toll-free: 1-888-759-4855

Electronic Claims Submission:
The following clearinghouses frequently submit claims electronically.

Electronic Network Systems (www.enshealth.com)

Toll-free: 1-800-341-6141

WebMD/Envoy (www.WebMD.com)

Toll-free: 1-800-215-4730

ProxyMed (www.proxymed.com)

Toll-free: 1-800-586-6870

Provider Credentialing and Contracting Issues

- Billing manuals and payment policies
- Change of provider status
- Fee schedules
- Network provider applications and contract information
- New provider enrollment
- Policies and procedures
- *Provider Bulletin* feedback

Health Care Authority
Uniform Medical Plan
P.O. Box 91118
Seattle, WA 98111-9218

Toll-free: 1-800-292-8092
Local: 206-521-2023
Fax: 206-521-2001

Prescription Drugs (retail and mail-order)

- Benefits information
- Claims information
- Cost share information
- Eligibility verification
- Preferred drug list information
- Prior authorization requests
- Network pharmacy information (location and network verification)

Express Scripts, Inc.
Member Services:

Toll-free: 1-866-576-3862

Drug Coverage Review and Prior Authorization:

Toll-free: 1-800-417-8164

Fax: 1-877-697-7192

Appeals and Correspondence:

Toll-free: 1-800-417-8164

Fax: 1-877-852-4070

Express Scripts, Inc.
Attn: Pharmacy Appeals: WA5
Mail Route BL0390
6625 West 78th Street,
Bloomington, MN 55439

Mail Service Pharmacy (refills):

Toll-free 1-866-576-3862

Licensed Acupuncturists, Licensed Massage Practitioners, and Naturopathic Doctors Network

- Network provider enrollment and contract information
- Billing procedures
- Fee schedule and payment policy information

Alternáre Health Services, Inc.
Toll-free: 1-800-500-0997
Local: 206-405-2923

Tobacco Cessation Services

Free & Clear
Toll-free: 1-800-292-2336

1.1.2 Web Site Information

UMP Neighborhood

www.ump.hca.wa.gov

- UMP *Billing & Administrative Manual* (includes billing and payment policy information for UMP Neighborhood)
- *Certificate of Coverage* (benefits book)
- Care System provider directories
- *Preferred Drug List*
- *Professional Provider Fee Schedule*
- *Anesthesia Fee Schedule*
- *Chiropractor Fee Schedule*
- *Prosthetic and Orthotic Fee Schedule, Including Ostomy and Urological Supplies*
- Other important information

U.S. Preventive Services Task Force Guidelines
www.ahcpr.gov/clinic/uspstf/uspstables.htm

- Preventive care guidelines

Express Scripts, Inc.
www.express-scripts.com

- General prescription drugs information

Note: See the UMP Web site (**www.ump.hca.wa.gov**) for UMP-specific information for prescription drugs.

Free & Clear
www.freeandclear.org/brochure

- Tobacco cessation program information

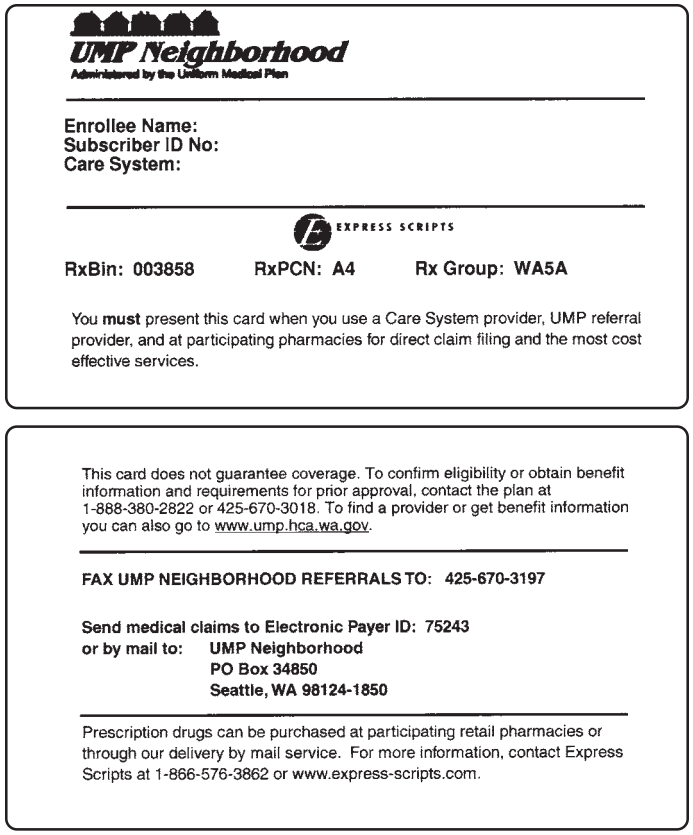
Alternáre Health Services, Inc.
www.alternare.com

- Licensed Acupuncturists, Licensed Massage Practitioners and Naturopathic Doctors—network provider resources information

1.2

Sample UMP Neighborhood Identification Card

This is the identification card that confirms UMP Neighborhood enrollment. **Please note:** The card also identifies the applicable Care System selected by the enrollee. Except as explained in Section 4.1.3, UMP Neighborhood enrollees only receive the highest ("network") level of reimbursement when they use providers affiliated with the Care System that they selected.



UMP Neighborhood
Administered by the Uniform Medical Plan

Enrollee Name:
Subscriber ID No:
Care System:

EXPRESS SCRIPTS

RxBin: 003858 RxPCN: A4 Rx Group: WA5A

You **must** present this card when you use a Care System provider, UMP referral provider, and at participating pharmacies for direct claim filing and the most cost effective services.

This card does not guarantee coverage. To confirm eligibility or obtain benefit information and requirements for prior approval, contact the plan at 1-888-380-2822 or 425-670-3018. To find a provider or get benefit information you can also go to www.ump.hca.wa.gov.

FAX UMP NEIGHBORHOOD REFERRALS TO: 425-670-3197

Send medical claims to Electronic Payer ID: 75243
or by mail to: UMP Neighborhood
PO Box 34850
Seattle, WA 98124-1850

Prescription drugs can be purchased at participating retail pharmacies or through our delivery by mail service. For more information, contact Express Scripts at 1-866-576-3862 or www.express-scripts.com.

1.3

Claims Submission Information

Paper claims (CMS-1500) should be mailed within 60 days of service (but not beyond 365 days) to the UMP Neighborhood claims office at the following address:

UMP Neighborhood
P.O. Box 34850
Seattle, WA 98124-1850

Claims with missing, inaccurate, or invalid information will be denied or sent back for clarification and resubmission.

Electronic claims submission provides efficiency to your business.

If you are already connected to one of the following clearinghouses that frequently transmits claims electronically, submit your UMP Neighborhood claims to payer I.D. number 75243.

Electronic Network Systems (www.enshealth.com)

Toll-free:..... 1-800-341-6141

WebMD/Envoy (www.WebMD.com)

Toll-free:..... 1-800-215-4730

ProxyMed (www.proxymed.com)

Toll-free:..... 1-800-586-6870

If you are currently submitting paper claims, we encourage you to contact a clearinghouse for information on submitting claims electronically.

1.4

Provider Network Participation

UMP Neighborhood benefits are structured to encourage enrollees to use the services of providers affiliated with the Care System that they selected. As a financial incentive and to promote quality of care, the plan applies considerable cost sharing for enrollees who self-refer to providers who are not in their Care System or on their Care System's panel of referral specialists. There are exceptions for certain provider types (see Section 4.1.3).

Care System providers are expected to refer patients to other providers within their Care System or to specialists who are on their Care System's panel. When it is necessary to refer a UMP Neighborhood patient to a provider who is not affiliated with the patient's Care System, referrals should be to a UMP PPO network provider for services to be reimbursed at the network benefit level. See Section 4.1.3 of this billing manual supplement for instructions on notifying our claims administrator of referrals outside the patient's Care System.

The UMP Neighborhood online directory (updated monthly) is available on the Web site at **www.umpneighborhood.com**. You can also view the UMP PPO's online provider directory and network pharmacy directory on the UMP Web site at **www.ump.hca.wa.gov**. A provider's participation status can also be confirmed by calling the UMP Neighborhood at 1-888-380-2822 or 425-670-3018. For referral to a Uniform Medical Plan PPO provider, call 1-800-464-0967 or 425-670-3046.

Section 2

Program Outline

2.1

Overview of UMP Neighborhood

UMP Neighborhood is a pilot product administered by the Uniform Medical Plan (UMP) for coverage beginning January 1, 2004. Because this is a pilot, enrollment was offered to a limited number of residents of King, Snohomish, and Pierce counties during the 2004 open enrollment period only. UMP Neighborhood enrollees have the same benefits as those enrolled in the UMP's traditional preferred provider organization (PPO), but they receive care from a more limited choice of network providers. The plan's goals include offering incentives to both providers and enrollees to make cost-effective health care decisions, and providing more affordable plan choices for PEBB members.

UMP Neighborhood is built upon organized "systems of care" consisting of primary care providers, and a panel of specialists and facilities chosen by the Care System. The primary care providers can only participate in one Care System. Specialists and hospitals may participate in multiple Care Systems.

There are 11 UMP Neighborhood Care Systems participating in 2004. They are identified with their Care System code on the Web site at **www.ump.hca.wa.gov/nhood/** and in the *UMP Neighborhood Provider Directory*. The directory also includes information provided by each of the Care Systems about their program.

Refer to the *UMP Neighborhood Certificate of Coverage* (COC) for deductible, coinsurance, and copayment requirements, as well as for a complete description of plan benefits and scope of coverage. The COC is available on the UMP Web site at **www.ump.hca.wa.gov/nhood/** or by calling 1-888-380-2822.

2.2

Fee Schedule Methodology and Coding Information

Refer to Section 2.2 of the UMP *Billing & Administrative Manual* for fee schedule, coding, and payment information that are also applicable to UMP Neighborhood. **Please note:** UMP Neighborhood uses the Uniform Medical Plan (UMP) fee schedule(s) for reimbursement of claims. The UMP fee schedules are available on the UMP Web site at **www.ump.hca.wa.gov**.

Section 3

Billing Instructions

Refer to Section 3 of the *Billing & Administrative Manual* for instructions to complete the CMS-1500 claim form. Information pertaining to the coordination of benefits process, explanation of benefits (EOB), and detail of remittance (DOR) notices is also available in this section. See Appendix A-6 for a sample of the UMP Neighborhood EOB and Appendix A-7 for a sample of the UMP Neighborhood DOR.

Section 4

Provider Information

4.1

Provider Requirements

UMP Neighborhood Care System providers agree to comply with the following requirements.

4.1.1 Credentialing Information

- Maintain applicable licensure, registration, and/or certification.
- Maintain professional liability insurance coverage with limits of liability as determined by the HCA/UMP.
- Meet all other UMP Neighborhood credentialing requirements.
- Submit provider updates following the UMP Adds/Terms/Changes (ATC) submission process provided in Appendix A-8.
- Accept UMP fee schedules and follow network provider policies and procedures.

4.1.2 Billing Information

Refer to Section 4.1.2 of the UMP *Billing & Administrative Manual* for billing information that is also applicable to UMP Neighborhood.

4.1.3 Referrals and Authorizations

UMP Neighborhood Care Systems are responsible for managing their panel of providers, including referral specialists. In most cases, UMP Neighborhood enrollees must use the providers in their selected Care System or its panel of referral specialists to obtain the maximum level of benefits. When referring a patient for care outside of their Care System's panel, Care System providers should refer UMP Neighborhood enrollees to a provider within the UMP PPO network unless one is not available for the type of care needed. In addition, the Care System provider should issue a UMP Neighborhood Pass when referring the patient outside of their Care System's panel. The main purpose of the UMP Neighborhood Pass is to notify our claims administrator how to reimburse the claim. With the pass, covered services provided by the UMP PPO network providers are paid at the network benefit level (usually 90 percent of allowed charges, after the enrollee's annual medical/surgical deductible has been met). Covered services provided by providers not in the UMP PPO network are paid at the out-of-network benefit level (usually 80 percent of allowed charges, after the deductible has been met).

Please note that Care System providers do not need to notify our claims administrator of a referral to the following provider types. Enrollees receive network-level benefits when self-referring to any UMP PPO network provider of the following types. Note below some limits on services when self-referring.

- Acupuncturists
- Alcohol/chemical dependency centers and substance abuse treatment facilities
- Ambulatory Surgical Centers
- Audiologists
- Behavioral Health Counselors, including Licensed Mental Health Counselors, Licensed Masters of Social Work, Licensed Marriage and Family Therapists, and Licensed ARNPs with training in psychology and counseling
- Chiropractors
- Community mental health agencies
- Durable medical equipment suppliers
- *Free & Clear* tobacco cessation program
- Free standing optometry clinics
- Hearing aid fitters and dispensers
- Home health or hospice agencies
- Home infusion provider
- Massage practitioners (requires a written treatment plan from your care system clinician, and must be a UMP PPO network provider)

- Naturopathic physicians
- Optometrists (if outside care system, self-refer only for routine vision services)
- Ophthalmologists (if outside care system, self-refer only for routine vision services)
- Pharmacists
- Pharmacies
- Prosthetic and orthotic suppliers
- Psychologists (licensed)
- Psychiatrists (licensed)
- Skilled nursing facilities
- State mental hospital
- Vision hardware vendors

The following hospital/facility-based physicians who may not be included in the patient's Care System but are necessary for the treatment of the patient will be considered as "in Care System" providers if they are in the UMP PPO provider network:

- Anesthesiologists
- Emergency room physicians
- Radiologists
- Hospitalists
- Pathologists

Finally, the following facilities/ suppliers that are generally not selected by the patient are also considered "in Care System" if they are in the UMP PPO provider network:

- Free-standing Radiology Facilities (including physicians interpreting the x-rays)
- Independent Lab Facilities

Ambulances and free-standing urgent care facilities will be covered at out-of-network benefit level (usually 80 percent of allowed charges after the enrollee's annual medical/ surgical deductible has been met).

A sample of the UMP Neighborhood Pass for referrals outside of the Care Systems is included on the following page. The pass is also available online. The Care System should fax the completed pass to UMP Neighborhood at 425-670-3197, or complete it online and e-mail it through our secure Web site. In addition, the Care System should give a copy of the pass to the patient for the provider to whom they are referred.

4.1.3.1 Self-Referral for Women's Health Care

For covered women's health care services, UMP Neighborhood enrollees will receive network-level benefits when they self-refer to a UMP PPO provider (physician, physician assistant, midwife, or advanced registered nurse practitioner)—regardless of whether the provider is affiliated with their Care System. Women's health care services include:

- Maternity care, reproductive health services, and gynecological care;
- General examinations, preventive care, and medically appropriate follow-up visits for the services previously mentioned or other health services particular to women;
- Appropriate care for other health problems that are discovered and treated during a visit for covered women's health care services.

If a woman self-refers to a non-network provider within Washington State for women's health care services, covered services will be reimbursed at the non-network benefit level.

UMP Neighborhood
Administered by the Uniform Medical Plan

UMP Neighborhood Pass

For _____

For Referrals Outside the Care System

Please fax to UMP Neighborhood at 425-670-3197, or complete form online and e-mail through our secure Web site at* www.ump.hca.wa.gov*.

Note: This form does not imply coverage of services not covered by UMP Neighborhood, or those requiring preauthorization. See the *UMP Neighborhood Certificate of Coverage* for details.

***Provider**: Please give the patient a copy of this form.* ***Patient:** Give your copy to the provider to whom you are referred.*

Patient and Subscriber Information

Patient Name _____ Date of Birth _____

Subscriber Name _____ Subscriber ID # _____

Patient Home Phone _____

Provider To Whom Referral is Being Made

Referred To

_____ Provider (Last, First)

_____ Type of Provider (such as M.D. or D.O.)

_____ Street Address

_____ Specialty

_____ City/State/ZIP Code

_____ Phone Number

Reason for Referral and Referring Provider

Diagnosis _____ ICD-9 Code _____ Date of Referral _____

Reason for referral _____

_____

Expected length of treatment _____

Referral requested for ☐ Consultation ☐ Consultation/Test/Treatment ☐ All Services

Referred By

_____ Print Provider Name

_____ Provider Address

_____ Provider Signature

_____ City/State/ZIP Code

_____ Phone Number

_____ Fax Number

HCA 57-170 (12/03)

Section 5

Enrollee Responsibilities

5.1

Enrollee Requirements

UMP Neighborhood enrollees should seek all medical care through providers within the Care System as identified on their I.D. card, except for providers/facilities that they can self-refer to as previously indicated in Section 4.1.3. If they seek medical care outside of the Care System without a UMP Neighborhood Pass where it is required, payment for covered services will be at the UMP non-network benefit level (generally 60 percent of allowed charges, after the enrollee's annual medical/surgical deductible has been met).

Subscriber education is an important factor in ensuring the timely and appropriate payment of health care benefits. When seeking health care, UMP Neighborhood enrollees have the responsibility to:

- Use their UMP Neighborhood Care System and network providers when available to help ensure quality care at the lowest cost.
- Identify themselves as a UMP Neighborhood enrollee when calling for an appointment.
- Present their identification card at the time services are rendered.
- Understand UMP Neighborhood benefits, including what's covered, preauthorization and review requirements, and other information described in the *Certificate of Coverage*.

UMP Neighborhood enrollees may change to a different Care System during the plan year with at least 30 days' notice. If the new Care System is accepting new patients, coverage is effective the first of the month following the 30 days' notice. In these circumstances, UMP Neighborhood will issue a new I.D. card to the patient to reflect the change to a different Care System.

If your patients have questions regarding UMP Neighborhood benefits, network provider status, or payment of their claims, please refer them to:

UMP Neighborhood Customer Service at:

Toll-free: 1-888-380-2822

Local: 425-670-3018

Section 6

Utilization Review Requirements

Refer to Section 6 of the UMP *Billing & Administrative Manual* for preauthorization and utilization review requirements, including review criteria and case management information that are also applicable to UMP Neighborhood. Care System providers are encouraged to contact case management on all catastrophic cases.

Section 7

Payment Rules

7.1 General Information

7.1.1 UMP Neighborhood *Certificate of Coverage*

The UMP Neighborhood *Certificate of Coverage* (COC) (available on the UMP Web site at **www.ump.hca.wa.gov** or by calling 1-888-380-2822) is the official source of plan benefits and scope of coverage information. Throughout the billing manual, key information from the COC that is pertinent to the benefit under discussion may be referenced for the provider's information. Providers must rely on the COC itself to obtain full and complete information regarding the scope of coverage and benefit provisions of UMP Neighborhood.

7.1.2 Plan Payment Provisions for Providers

Unless otherwise specified in the billing manual, the applicable calendar year deductible must be satisfied before UMP Neighborhood will make a payment for services provided under a given benefit.

Services exempt from the annual medical/surgical deductible include:

- Preventive care*;
- Retail and mail-order prescription drugs**;
- Routine vision exams and hardware;
- Required second surgical opinions; and
- Tobacco cessation services provided through the *Free & Clear* smoking cessation program.

* UMP Neighborhood follows the preventive care guidelines established by the U.S. Preventive Services Task Force (USPSTF) when determining coverage for preventive care. See Billing Manual Section 7.2.2, Preventive Care, for more information.

** The UMP Neighborhood has a separate annual deductible for prescription drugs. It is a combined retail and mail-order deductible. See the UMP Neighborhood *Certificate of Coverage* for more details.

After the enrollee's annual medical/surgical deductible has been met, the plan's payment provisions generally are as follows:

- For covered services from **providers affiliated with the enrollee's Care System, or from providers of the types listed in Section 4.1.3 who are contracted with UMP PPO,** the plan pays 90 percent of the allowable amount. (The "allowable amount" is the actual charge or the fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 10 percent.
- For covered services from **other providers**, the plan pays:
  - 90 percent of the allowable amount when a UMP Neighborhood Pass has been issued and the provider is a UMP PPO Network provider. (The "allowable amount" is the actual charge or the fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 10 percent.
  - 80 percent of the allowable amount when a UMP Neighborhood Pass has been issued and the provider is not a UMP PPO Network provider. (The "allowable amount" is the actual charge or the fee schedule amount, whichever

is less.) The enrollee is responsible for the remaining 20 percent plus the difference between the allowed amount and the billed charges.

- 60 percent of the allowable amount when a UMP Neighborhood pass has not been issued, regardless of whether the provider is a UMP PPO network provider or is participating as a UMP Neighborhood provider with a different Care System. (The "allowable amount" is the actual charge or the fee schedule amount, whichever is less.) In this circumstance, the enrollee is responsible for the remaining 40 percent if the provider is a UMP PPO network provider. A UMP PPO network provider cannot bill the enrollee for the difference between the billed and allowed charge. If the provider is not a UMP PPO network provider, the enrollee is responsible for the remaining 40 percent plus the difference between the allowed amount and the billed charges.

For all providers (Care System, UMP PPO, out-of-network and non-network), the UMP fee schedules and payment policies determine the allowed charges used for UMP Neighborhood reimbursement. These fee schedules and the UMP billing manual are available on the UMP Web site at **www.ump.hca.wa.gov**. Note that a payment differential applies to payments for certain categories of providers. This differential is described in Section 7.1.3 of the *UMP Billing & Administrative Manual for Professional Providers*.

In referral situations where a UMP Neighborhood Pass is not required as indicated in Section 4.1.3, UMP Neighborhood payment is based on the network or non-network status of the provider and the applicable benefit.

Emergency care from non-network or out-of-area providers is based on 80% of allowed charges.

Non-urgent, non-emergent care outside of Washington State is not covered, unless referred by Care System Provider.

For details regarding UMP Neighborhood enrollee's benefits and scope of coverage, see the UMP Neighborhood *Certificate of Coverage*. As explained in that document, UMP Neighborhood enrollees have an annual out-of-pocket limit, as well as some benefit limits. When benefits are paid as network or "out-of-network" (generally used to refer to situations when the enrollee did not have access to network services, as determined by UMP), the enrollee's coinsurance and copayments count towards their annual out-of-pocket limit. "Non-network" services (used to refer to all other situations, when the enrollee had access to network services but did not use them) are not counted towards the enrollee's out-of-pocket limit. Once the enrollee's out-of-pocket limit is reached, most network and out-of-network services will be paid at 100 percent for the remainder of that calendar year. Specific benefit limits, however, still apply.

Note: Services rendered under private contracts by providers who "opt out" of the Medicare program will not be covered or reimbursed by UMP Neighborhood. Exceptions are services provided on an emergency/urgent basis or that are excluded under the Medicare program, such as routine eye exams and certain preventive care services/procedures, which will be processed and paid according to UMP Neighborhood benefits. In a private contract situation, the enrollee is solely responsible for the provider's total billed charges.

Refer to Sections 7.1.3 through 7.18 of the billing manual for additional payment rules and other information that are also applicable to UMP Neighborhood.

Section 8

Provider Inquiries, Complaints, Reconsideration Procedures and Dispute Resolutions

Refer to Section 8 of the UMP billing manual for procedures for inquiries, complaints, claims reconsideration requests, and dispute resolutions that are also applicable to UMP Neighborhood.

Appendix A-6 UMP Neighborhood Explanation of Benefits (EOB) Example

UMP Neighborhood
Administered by the Uniform Medical Plan

UMP NEIGHBORHOOD
PO BOX 34850
SEATTLE WA 98124-1850

A BENEFIT PROGRAM FOR EMPLOYEES OF WASHINGTON STATE

Important: Keep this for your permanent records and tax purposes

For questions or review of the decision, please write:
UMP NEIGHBORHOOD
P O BOX 34850
SEATTLE WA 98124-1850

For questions or review of the decision, please phone:
1-888-380-2822 Toll Free

TEST
19401 40th AVE. W Ste 200
Lynnwood, WA 98036

Employee: TEST
Patient: TEST
Relationship: EMPLOYEE
Member ID: 999999999
Patient Acct No: 01
Provider No: 999999999
Claim No: TEST CLAIM-00
Date: 01/10/2004

EXPLANATION OF BENEFITS

Provider/Date(s) of Service	Proc. Code	Billed Charge	Non Covered Amount	Message Code	PPO Savings	Allowed Amount	Applied to Deductible	Balance	Pct %	Total
PHYSICIAN MD 03/20/04 - 03/20/04	99213	75.00		PPU	9.63	65.32		65.32	90	58.79
PHYSICIAN MD 03/20/04 - 03/20/04	74000	60.00		PPU	16.93	43.07		43.07	90	38.76
TOTALS		135.00			26.56	108.39	0.00	108.39		97.55
									Less Adjustments:	0.00
									Total:	97.55

Employee Responsibility **10.84**

Other Insurance Paid **0.00**

Messages

THANK YOU FOR USING A UMP NEIGHBORHOOD
PARTICIPATING PROVIDER
PPU THIS IS YOUR PLAN'S NETWORK CONTRACTUAL ALLOWANCE FOR THIS SERVICE.
PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.

Accumulators

YOU HAVE MET 200.00 OF YOUR 200.00 DEDUCTIBLE FOR 01/01/2004 - 12/31/2004

UMP NEIGHBOR HOOD
P O BOX 34850
SEATTLE WA 98124-1850
Toll Free: 1-888-380-2822

DOCTORS CLINIC
PO BOX 999
SEATTLE WA 98124

PHYSICIAN MD

SEE LAST PAGE FOR
EXPLANATION OF CODE

PROV#: 999999999900
TAX#: 9999999999
DATE: 05/02/2004
Draft #: 0000000
ENVOY/NEIC ID#: 000000000

PATIENT NAME / ACCOUNT #	BENEFIT ID # / CLAIM #	APC	SVC DATE	REV/PROC CODE	#	BILL AMOUNT	ALLOWED AMOUNT	NONCOV'D	CODE	DEDUCTIBLE AMOUNT	COPAY COINS	PPO DISCOUNT	PATIENT BALANCE	AMOUNT PAID
TEST C999999	999999999 TEST CLAIM-00													
			03/20/04	99213	1	75.00	65.32	.00	PPU	.00	6.53	9.63	6.53	58.79
			03/20/04	72040	1	60.00	43.07	.00	PPU	.00	4.31	16.93	4.31	38.76
	APDRG			**CLAIM TOTAL**		**135.00**	**108.39**		**.00**		**.00**	**10.84**	**26.56**	**10.84**

Pavment 97.55

TOTAL PAID 97.55

Code Descriptions

****
PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE LISTING TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT PAYMENT AMOUNT.
****

PPU THIS IS YOUR PLANS PARTICIPATING PROVIDERS CONTRACTUAL ALLOWANCE FOR THIS SERVICE. PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.

******* REQUESTS FOR RECONSIDERATION OF THE WAY A CLAIM WAS PROCESSED, TO INCLUDE BUNDLING, COB OR ALLOWABLE FEE ISSUES, SHOULD BE DIRECTED TO: UNIFORM MEDICAL PLAN, P.O. BOX 34578, SEATTLE, WA 98125-1578

Adds/Terms/Changes (ATC) Submission Process

This section applies to both UMP PPO and UMP Neighborhood as described below.

I. Additions

A. **Delegated Providers**
Provide UMP Provider Services a spreadsheet or Provider Profile, in writing or on diskette that includes the following information. ***Provide updates on a monthly basis:***

1. Name and professional degree
2. Gender
3. Date of birth
4. Specialty
5. Social Security number
6. DEA number (if applicable)
7. UPIN or NPI number (if applicable)
8. Washington license or certification number
9. Practice location and phone number
10. Billing address information
11. Copy of W-9 form
12. Accepting new patients (yes or no)
13. Advertise in provider directory (yes or no)
14. Obstetric services (yes or no)
15. Optional: Language(s) other than English; after-hours phone number/pager

B. **Solo and Non-Delegated Providers**
Call Provider Services to request a new provider application packet at 1-800-292-8092. Complete and submit the new provider application/provider profile as instructed.

II. Terminations

Notify Provider Services of termination date of network provider:

Via e-mail to :

umpprovider@hca.wa.gov

By mail:

Uniform Medical Plan
P.O. Box 91118
Seattle, WA 98111-9218

By fax: 206-521-2001

III. Changes

Notify Provider Services in writing via e-mail, fax, or mail (as shown earlier) of any change of the preferred provider status—i.e., provider name; address change; tax I.D. change; formal or informal disciplinary actions; Medicare Sanctions; loss of hospital privileges; loss of malpractice coverage, etc.

Process for Updating Specialist Referral Panels

(this applies to UMP Neighborhood Care Systems only)

UMP Provider Services will send a monthly report to each Care System with a list of their designated referral providers. Each care system should update this report with any changes (additions, terminations, etc.) and return it to UMP Provider Services promptly. (**Note**: Any changes will be noted in the UMP Neighborhood online directory, which is updated once a month.)